State of Maryland / Department of Health and Mental	Hygiene 0	0850
Certificate of Death	Reg. No.	0000

		Certificate of	Death	Reg.	No.	- C C C I
Dharle	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
Physician /Medical	MILDRED E. LENHART			FEBRUAR		1:10 PM
Examiner	4a Facility Name (If not institution, give street end number)		4b. City, Town, or Loc	cation of Death	4c. County of Deat	h
	HILLHAVEN NURSING CENTER	}	ADELPH:		PRINCE	GEORGES
uneral		s. last birthdey) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Dey, Ye	9. Birt	hpiace (State or Forei untry) PA.
rector	217-44-2464 1 ¹ M 2 TF 83	Yrs.		JULY 31,	1915	PA.
	Usual Residence of Decedent	Dia. Town out another				104 12-14- 07-11-1
23a or 28a-f ehow	10a. State 10b. County 10c. 0	City, Town or Location				10d. inside Oily Limi
cto de	MD. PRINCE GEORGES	HYATTSVI	LLE			
or 2	10e. Street and Number	10f. Zip Code		10g.	Citizen of What Co	untry?
239	5821 QUEENS CHAPEL RD.#10	1 20'	782		U.S.A	•
flams funer	11. Marital Status 12. Was Decedent Ever to Armed Forces?	U,S. 13. Was Decedent of H	dispanic Ortgin? (Spe an, Mexican, Puerto F	city Yes or No- Rican, etc.)	14. Race - Ame Black, White	
5 8	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 🔯 No	Specify:		Specify:	
	3 ☐ Widowed 4 ☐ Divorced Year or Dates:				ороспу.	WHITE
it, the Madeal.	15. Decedent's Education (Specify only highast grade completed)	16a. Decedent's Usual Occup (Give kind of work done	during most of working	160	b. Kind of Businass/	Industry
npi npi	Etementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired	d)			
CO LE	12	BOOKKEEPI	T		FED. GO	V'T.
d oth	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Mei	den Sumame)	
To the	WILLIAM G. LENHAR	T	MA	BEL A.	HAMME	LMAN
EE	19a. Informant's Name/Retationship (Type, Print)	19b. Maliing Address (Street	end Number or Rure	l Route Number, C	ity or Town, State, 2	(ip Code)
Important: If item 27 is marked other than eny injury or other treumatic event, the Magnes. To Be Compi	MICHAEL DOUGHERTY/FRIEND	11412 SEQUO	IA LA., BE	LTSVILLE	, MD. 207	05
to the	Total Motivior of Dioposition	. Place of Disposition (Neme of cemetery, cremetory or other place)	ce)	Date 20	c. Location - City or	Town, State
7 0	1 ☐ Buriai 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	HAMBERS CREMATO		1/99	RIVERDAL	F MD
Importa any inju pace.	21. Signature of Funeral Service Lifensee	22. Name and Addre		1-1-1-		
in and haltransit Examiner	b. MyE	(or as a consequence of): Lo PRoLIFERA (or as a consequence of):	TIVE DI	SORDER	ζ	1-1-86
been signed by the attending physician and should be datached for usa as the burial-transit leted by Physician/Medical Examir	if any leading to immediate	(or as a consequence of):				
physicia is the bur edicai	cause. Enter Underlying Causa (Disaasa or injury that initiated events	(or as a consequence of):				
edi th	resulting In death) Last	(or as a consequence or).				
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or, pa	25. Was case raferred to medical				2,6140	10 162 50 140
ractor, pag rector, pag Be Co	examinar?	Ot	26. Place of Death			
this or ral dire	1 ☐ Yes 200 No ☐ Inpatient 2 27. Manner of Death 28a. Date of injury	LI EN Outpatient 3LI DOX	4 pa rursing nor	ne 5 Li Resideno 28d. Describe how	be 6 Other (Spe	city)
To the Funeral Director: After completely filled in by the funer completely filled in by the funer medical Certification:	1 ☑Natural 5 ☐ Pending (Month, Dey Year)		ryat ork?]Yes 2 □ No	200. 2000/100 1101	injury cocurred	
ol Director: After to led in by the funeral Certification:	3 Suicide 6 Could not be	home, farm, street, factory, office		28f Location (Street	et end Number or R	ural Route Number
in by	4 Homicide determined 209. Place of Injury - At building, etc. (Spe	cify)	1	City or Town,		and a route reamber.
Medicai Certification: To Be Com	29a. Certifier 18 Certifying Physician: To the bast of my k					
plataly fill edical	29a. Certifier (Check only one) (Check on					
N Ple	29b. Signature and title of certifier	29c. Licens	se number	29d	. Date signed (Mont	h Dev Year)
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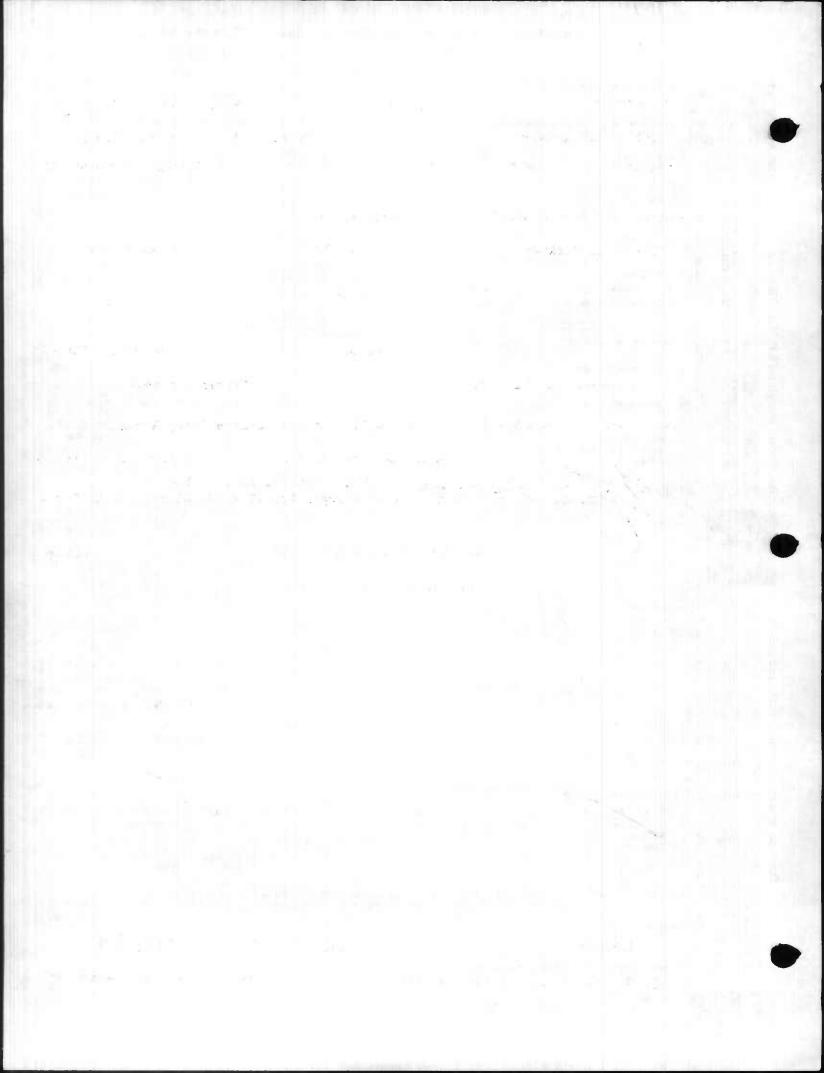
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Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Feb. Day 26 **Physician** CARRIE Ρ. LEWIS 1999 8:40 P.M. /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7205 Wells Parkway Hyattsville Prince George's If Under 24 Hrs. 8. Date of Birth May 199, 1925 if Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2\ F Months Days Hours Min. Richimond, VA. 73 578 62 1249 Yrs. **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mantal Hygiene. Important: If item 27 is marked other than "naturel", or items 23e or 28a-f show any injury or other traumatic event, on Medical Examiner must be inclified at once. 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 No Prince George's Hyattsville Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20782 7205 Wells Parkway United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Marital Status Biack, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ Black 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher D.C. Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Howard W. Page Sr. Carrie Poindexter 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. tnformant's Name/Relationship (Type, Print) Lola Colyar (Daughter) 7205 Wells Parkway, Hyattsville, Maryland 20782 20a. Method of Disposition 20b. Ptace of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removat from State Chesapeake Crematory Inc. 4 ☐ Donation S☐ Other (Specify) Beltsville, Maryland ²² Name end Address of Fecility MCGuire Funeral Service Inc. 7400 Georgia Ave., N.W., Washington, D.C. 20012 Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory arrest, or near failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Physician /Medical Immediate Quase (Final disease or condition resulting in death) ALZIEMER S 10 yrs Examiner Due to (or es a consequence of): Examiner HYPERTENSION physician and s the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or trijury that initiated events resulting in death) Last Due to (or as a consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 8 950 0 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? Completed peen page 2 s has 1 Yes 2 DNo 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 28d. Describe how Injury occurred Certification: 28b. Time of 5 Pending investigation 1 Natural s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide within 24 hours after de To the Funeral Directo 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Wedical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner stated. Within 2 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Paniel D0050951 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RIVERDALE AUENUE 6510 KENILWORTH REVA. S GILL 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State MAR 0 2 1999 oak Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #8,3/4/99, BMW, Montg. Co. 1. Decadant's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Day GAMBLE 24, 1999 ELOISE LOUALLEN FEBRUARY 8:55 am 4a. Facility Nama (If not institution, give streat and number) 4b. City, Town, or Location of Deeth 4c. County of Death 11e Prince George 8. Data of Birth 1943 9. Birthplace (State Country) May 22, 1999 NC 7101 24th Place Hyattsville if Undar 24 Hrs. 8 Dat Hours Min. (Mo If Undar 1 Yaar Months Days 5. Sociei Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (State or Foraign Country) 1 M 2 XF 55 Yrs 579-54-6687 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Yas 2□No MD Prince George Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 7101 24th Place 20783 United States 12. Was Dacedent Ever in U,S. Armed Forcas? Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 11. Maritei Status Raca - American Indian, Black, Whita, atc. 1 ☐ Yas 2 🛣 No If Yas, Giva Yeer or Detes: 1 Navar Marriad 20 Marriad 1 ☐ Yas 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 12th Staff Assistant Federal Government 17. Father's Nema (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumame) Cleveland Gamble Zelphia Bethea 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straet and Number or Rural Route Number, City or Town, Stata, Zip Code) Alvin Louallen /husband 7101 24th Place, Hyattsville, MD 20783 20b. Place of Disposition (Name of cematary, cramatory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stata Data Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) Harmony Memorial Park 3/6/99 Landover, MD 21. Signature of Funaral Sarvice Licensee 22. Name and Address of Facility R. N. Horton Co. Morticians, Inc.) Loton 600 Kennedy Street, N.W., Wash., DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximata Intarval Batween Onset and Death Haemosshorge Immediata Cause (Final disease or condition rasulting in death) Dua to (or es a consaguence of) Sequantially list conditions, if eny, laading to immadiata ceusa. Enter Underlying Causa (Disease or Injury that initiated events rasulting in death) Lest Dua to (or as a consequence of): Due to (or as a consaquance of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Wara autopsy findings eveilabla prior to complation of causa of death? 1 ☐ Yas 2 ☑ No 1 ☐ Yas 2 ☐ No

Physician /Medical Examiner

permit. Pages 1 and 2 s Department of Health an Important: if itam 27 is any Injury or other trau

Physician

/Medical

Examiner

Funeral

Director

28a-f show

6 Itams 23a must be notflied at Director

traumatic event, the Medical Examiner

Pages 1 and 2 should be filed within 72 hours aftarnent of Health and Mental Hygiane. nt: If Itam 27 is marked other than "natural", or Ita

Baltimore, Maryland 21215-0020

Funeral

by

Completed

Be 2

the Maryland

death

Examiner sloian and burial-transit 88 page 2

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records.

physician s the buria Physiclan/Medical signed t þ Completed certificate Be 2 Certification:

To the Hospital or Attending Physician: within 24 hours after death.

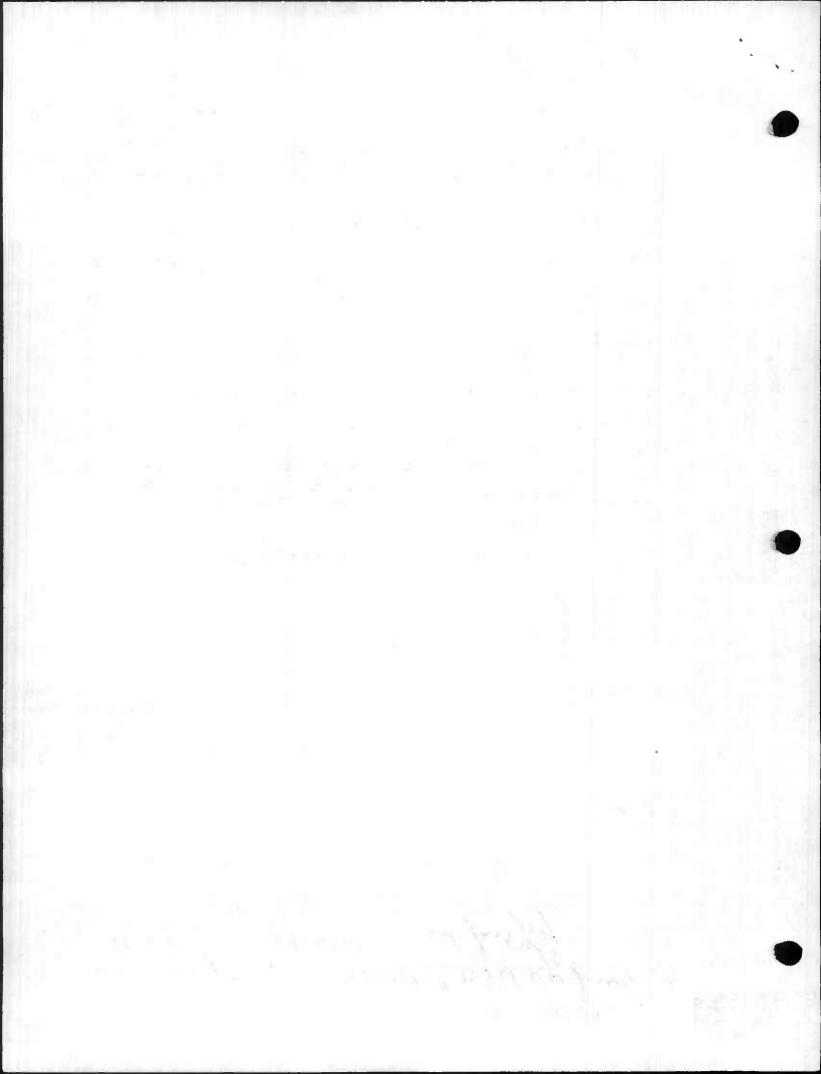
To the Funeral Director: After this certifica completely filled in by the funeral director, to 3

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was cese rafarred to medicel 26. Placa of Death (Check only ona) axaminer? Hospital: 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manger of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Dascribe how Injury occurred 1 Natural 5 Panding 1 Tyes 2 No Invastigation 2 Accidant 6 Could not be datarmined 3 Sulcida Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 - Homicide 29e. Cartifiar Medical 1 Certifying Physician: To tha best of my knowledga, deeth occurred at tha tima, date end piece, and dua to tha ceusa(s) and mannar as steted. (Check only one) 2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the ceusa(s) end manner stated. 29b. Signature and title of certifier 29c. Licensa number

29d. Data signad (Month, Day, Year)

30. Name, and address of perso deeth (Itam 23a) (Type, Print) Baltimore Ave Lamel MD. 20707 31

State Registrar 31. Date field Month, Day, Year) MAR 04 1999 32. Registrer's Signatura



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** rebruory 31, 17 840 ROBERT SMITH LIVEZEY, /Medical 4b. City, Town, or Location of Deeth 4a Facility Nama (If not Institution, giva straat and number) Examiner Fallston General Hospital Fallston Harford if Undar 24 Hrs. 5. Social Security Number If Under 1 Yaar 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Data of Birth (Month, Dev. Yeer) **Funeral** Deys M 2□ F Months Yrs. Director 219-10-4295 Apr. 25, 1926 Maryland Usuel Residenca of Decedent 10e Stete 10c. City, Town or Location 10h County 10d, Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2 No Directo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1034 East MacPhail Road 21015 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2☑ No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Married 25 Married 1 Yes 2√2 No Specify: Specify 20 3 Widowed 4 Divorced Yaar or Datas: White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) School Bus Contractor Transportation 11 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If New 27 is marked other t 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meidan Sumema) James Swartz Livezev Frances Baker Livezev 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Ralationship (Type, Print) 1034 East MacPhail Rd., Bel Air, MD Lora S. Livezev - Wife 20s. Method of Disposition 20b. Place of Disposition (Neme of Date 20c. Location - City or Town, State cametery, crametory or other placa) 1 (XBurial 3 🗆 9 ä 5 Other /Spec 3/3/99 Zion U.M Cemetery Bel Air, Maryland 21. Signature un Refaus 22. Nama and Addrass of Fecility Howard K. McComas III Funeral Home, 50 West Broadway, Bel Air, MD 21014 50 West Broadway, Bel Air, MD hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. **Physician** /Medical immediate Ceuse (Finei SEPSIS WEEK diseese or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner PURT - A WECTED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieled events rasulting in daath) Lest pue the buriel-tran Due to (or as e consequance of) KENIA ettanding physician Physiclan/Medicai Due to (or as a consaquance of): 80 950 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the causa of death? ate has been signed by page 2 should be datacl 1 Yes 2 No 3 Probably A Unknown) molce by 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24a. Wes en autopsy performed? Completed myochnising (WIFARE) 1 □ Yes 2 M N 1 □ Yas 2 □ No certificate Be 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Menner of Deeth 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Waturel fniury To the Hospital or Attendit within 24 hours after death. To the Funeral Director: At 1 ☐ Yes 2 ☐ No 2 Accidant 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) end menner es stated. Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier Medical 29b. Signetura and the of cartified 29d. Date signed (Month, Dev. Year) 29c. License number

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State Registrar

the Maryland

Maryland 21215-0020

Baltimore,

requiras that the daath certificete be executed

O. Box 68760

Division of Vital

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R. PHILCIPS

31. Date filed (Month, Day, Year)
MAR 0 2 1999

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

MCK NUI 32. Registrer's Slaneture

SPN INC6

A SEEL 28 STORY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Month **Physician** Ac. County of Deeth WILHELMINA LLOYD Feb. ANNA /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) **Examiner** Mariner Health of Bel Bel Air Air Harford If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, 5. Social Sacurity Number 7. Aga (in yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 F Months Deys Yrs. 218-07-9513 20/1909 Director Maryland Usual Residence of Decedent Marylend 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show treumstic event, the Med cal Examinar must be notified at 1 Yas 2 No Director Harford Street Md. the 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4208 Federal Hill Road 21154 U.S.A. Funeral 72 hours efter death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Giva Yaer or Detes: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No Specify: Specify: Caucasian p 3 Widowed 4 Divorced Completed 15. Decedent's Education ify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest g College (1-4or 5+) Elementery/Secondery (0-12) Statistical Clerk Social Hygia 18. Mother's Neme (First, Middla, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) 12 should be fill h and Mentel H le marked off Be Harry Patterson G. Annie Wilhelmina Velton 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Coda) 19e. Informent's Name/Reletionship (Type, Print) permit. Peges 1 end 2: Depertment of Health at Important: If Item 27 is any injury or other tree page. John D. Lloyd Jr. /Son same as #10 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 3/1 20c. Location - City or Town, Stete Buriel 2 Crametion 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Jarrettsville Cem. 1999 Jarrettsville, Md. 22. Name and Address of Facility E.G. Kurtz & Son Funeral Home, P.A. 21. Signature of Funerel Service Licen Jarrettsville, Maryland 23e. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel weeks disaase or condition resulting in deeth) **Examiner** Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): pertension ettending physician for use es the burie Physician/Medical Dua to (or es e consequence of): ed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 2 X No 3 Probably 4 Unknown þ 24b. Were eutopsy findings availeble prior to 24e. Wes en eutopsy Completed been completion of cause of deeth? page 2 hes 1 ☐ Yas 2 ☐ No certificate Physician: funeral director, Be 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28c. Injury et Work? Certification: 28e. Dete of tnjury (Month, Day Yeer) 28d. Describe how Injury occurred 27. Manger of Deeth 28b. Time of After 1 D Neturel 2 Accident Attending 5 Pending Investigation 1 Yes deeth. 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

of Vital Division To the Hospital C. within 24 hours after deet To the Funeral Director: after deetl Director:

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide

Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) end menner es stated.

Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner stated. 29e. Certifier

29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifie 29c. Licansa number Jun. Uh

and eddress of person who completed cause of deeth (Item 23e) (Type, Print) m.D

Harford Road, Fallston, MD

State Registrar

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Dey, Yeer) 32. Registrer's Signeture

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State of Maryland / Department of Health and Mental Hygiene

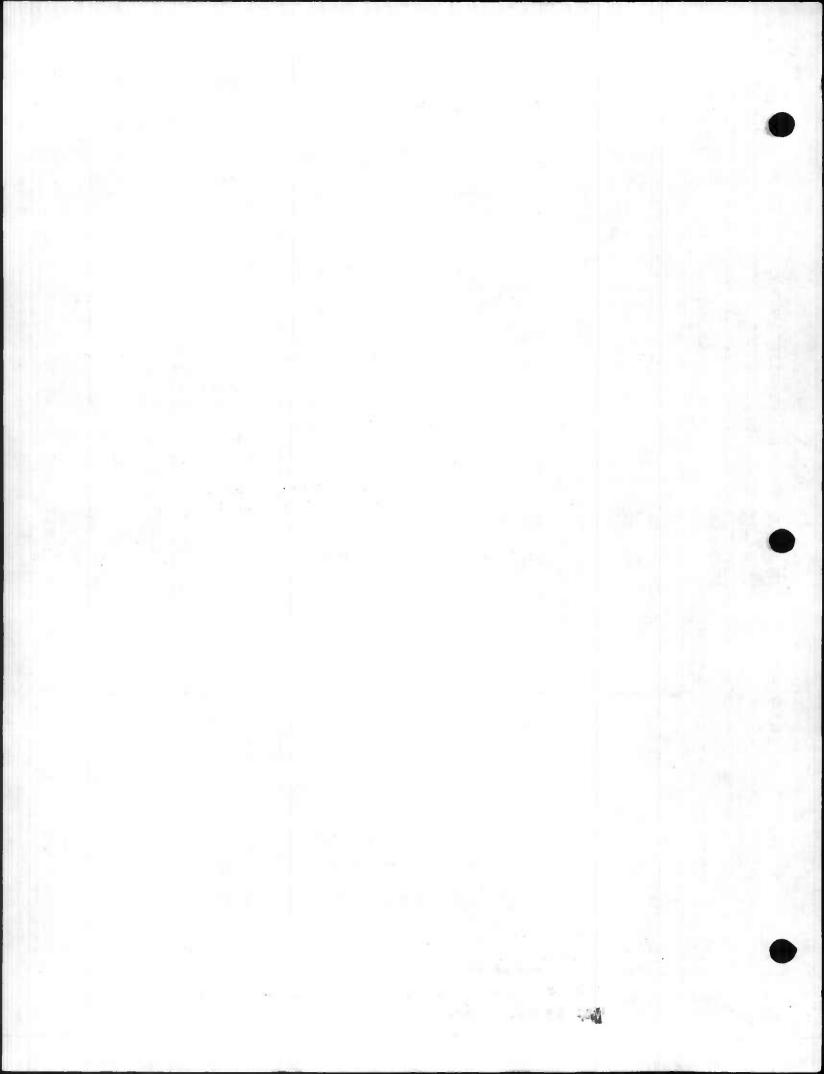
Certificate of Death 1. Decedent's Nama (First Middle Last) 2. Data of Death 3 Time of Death Month **Physician** Yaar March 3, Leslie 1999 Olga Mae 10:00 AM /Medical 4b. City, Town, or Location of Death 4e. Fecility Nema (If not institution, give street end number) 4c. County of Deeth Examiner 13121 Manor Drive Frederick Mt. Airy If Under 1 Yeer If Under 24 Hrs. 8. Deta of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stete or Foraign Country) **Funeral** Days 1□ M 2⊠ F Vrs Director 82 567-14-6163 Dec. 10, 1916 California Usual Residence of Dacedant 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examinar must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 219 No Director Maryland Frederick Mt. Airy 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? pemit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner mant once. 13121 Manor Drive 21771 United States Funeral 12. Was Dacedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - Amarican Indien, Black, Whita, atc. 1 ☐ Yas 2 🖾 No If Yes, Giva Yeer or Datas: 1 ☐ Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify. þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usuel Occupetion (Giva kind of work done during most of working lifa. DO NOT use ratired) 15. Dacedant's Education (Spacify only highest grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Coilega (1-4or 5+) Homemaker Own Home 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Name (First, Middla, Maiden Sumama) Be 2 Oscar Holden Nellie Fulmore 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stete, Zip Code) Philip Leslie / Husband 13121 Manor Drive, Mt. Airy Maryland 21771 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State Data 1 ☐ Burlal 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Metropolitan Crematorium Inc 3/5 Alexandria, Virginia 21. Signeture of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 ns that causad tha death. Do not antar tha mode of dying, such as cerdiac or raspiratory arrast, use on each line. Approximata Interval Between Onset end Death **Physician** Immediata Causa (Final disaasa or condition rasuiting in daath) HOVES /Medicai SASUS-C Examiner Dua to (or as a consequence of) Examiner attending physician end for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to Immadiata ceuse. Enter Undarlying Cause (Diseasa or injury that initiated avents rasulting in deeth) Last Dua to (or as a consequence of) Box 68760. Physician/Medical Dua to (or as a consequence of) P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings evailable prior to completion of cause of death? Osteoporosis Completed 24e. Was an autopsy hes page 1 ☐ Yes 2 ☐ No certificate or Attending Physician: Be 25. Wes case refarred to medical 26. Place of Daath (Check only one) axaminar? 1 ☐ Yas 280 No Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 27. Menner of Daath 1 Netural 2 Accident 28b. Tima of 28d. Dascribe how Injury occurred After 5 Pending invastigation i efter death.

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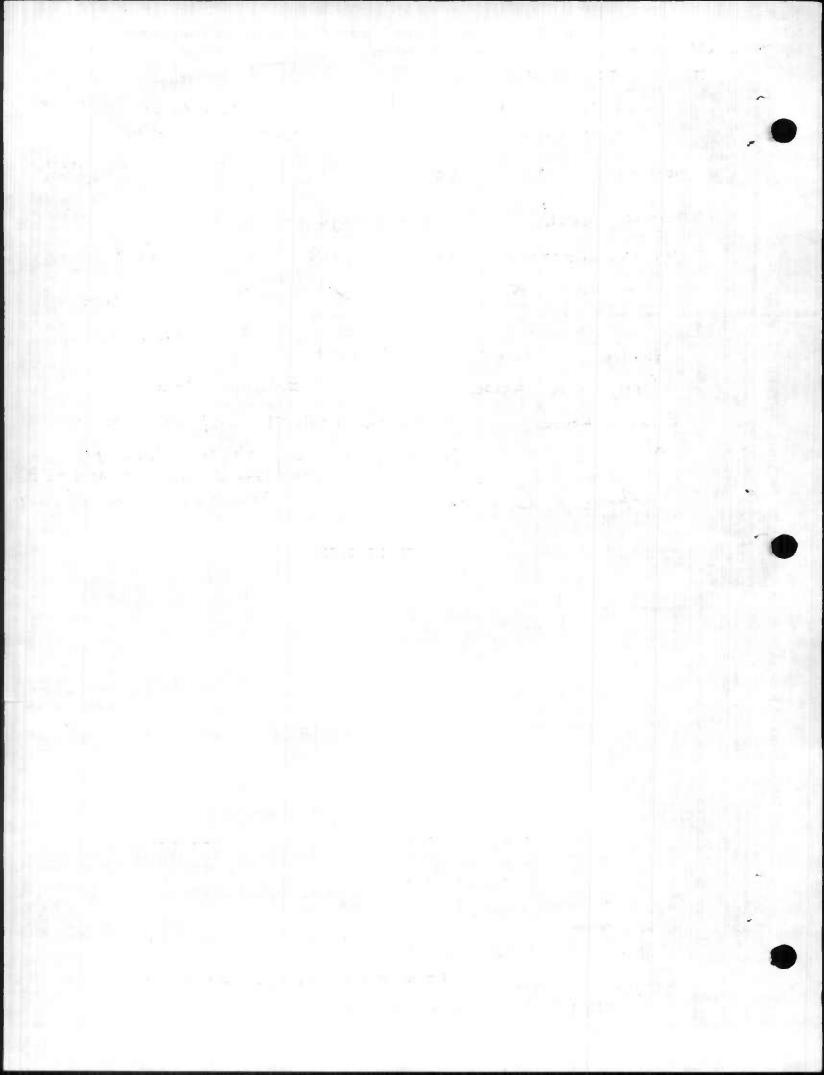
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar 29c. Licansa numbar March 3, 1999 30. Nama and address of person who complated causa of death (Item 23a) (Type, Print) James S. Grissom, M.D. 300 W 9th St., Frederick, Md. 21701 31. Data filed (Month, Dey, Yaer) 32. Ragistrar's Signatura State NR 08 1999 Spark Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time ol Death Physician CLAYTON EUGENE LAWRENCE March 1:33 am /Medical 4a Facility Nama (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 00 M 2□ F 213-38-0847 Yrs 59 Director May 16 1939 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23e or 28e-f ahow the Medical Exemples must be notified at 10d. Inside City Limits MD Montgomery Gaithersburg Director 1 TYes 2 No 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 9405 Hickory View Place 20879 U.S.A. death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baitimore, Maryland 21215-0020 1 Yes 2X No Specify: Specify: white à 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) self employed/carpenter 10 construction permit. Pages 1 and 2 should be file Department of Health and Mertial Hy Important: If item 27 is marked othe any Injury or other traumatic avant, phose. 17. Fether's Name (First, Middle, Last) 16. Mother's Neme (First, Middle, Maiden Sumame) Be James Lawrence Gloriene Neal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Martha Lawrence/sister in-law 6909 Damascus Rd. Gaithersburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Deta 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 3/3 4 ☐ Donation 5 ☐ Other (Specify) Monocacy Beallsville, MD 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Hilton Funeral Home 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD 20838 Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finat Ventricular minudes disease or condition resulting in death) Examiner Examiner physician and the burial-transit the death certificate be asscuted Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as e consequence of): P.O. signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, 2 24b. Wara autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? Completed 1 ☐ Yes 2 ☐ No certificate Division of VItal or Attending Physician: Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 1 Neturat 5 Pending investigation To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Yas 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, daeth occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d, Data signed (Month, Day, Year) 388 99 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) David Klein 8311 Aquaduct Rd. Potomac, MD 20854 ad (Month, Day, Year) 32 Registrary Signatura 31. Data filed (Month, Day, Year) State AR 03 1999 Registrar

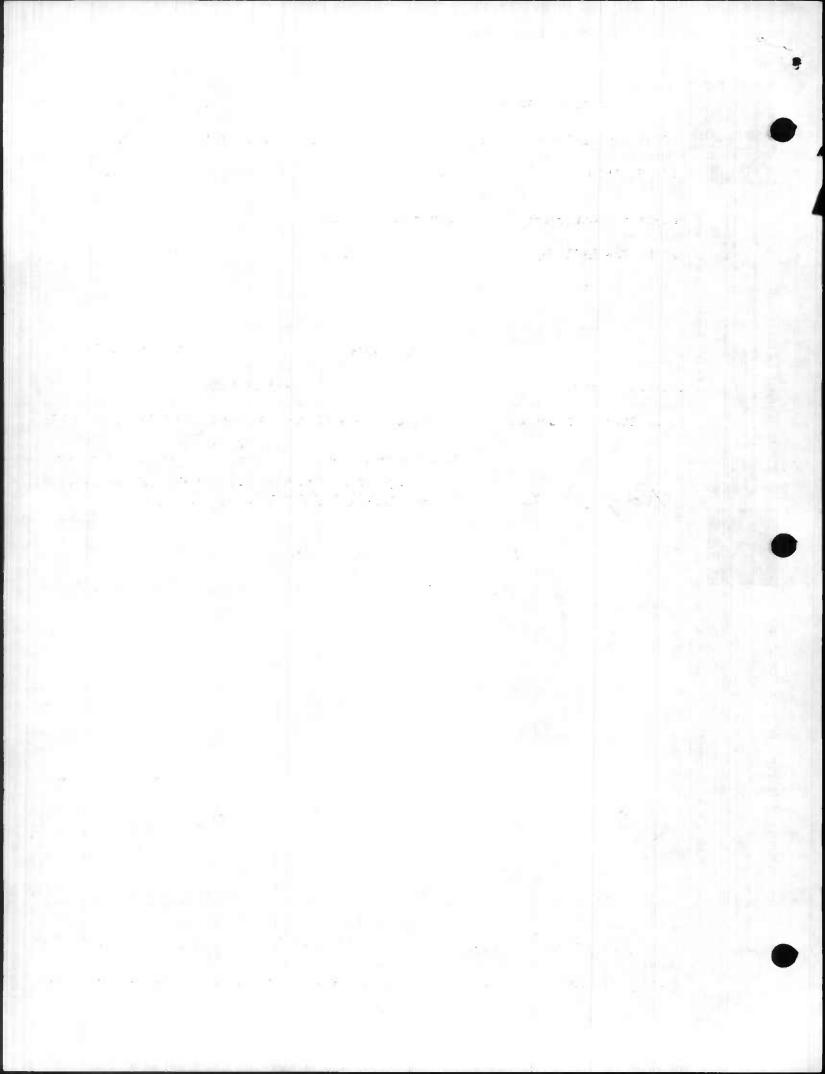


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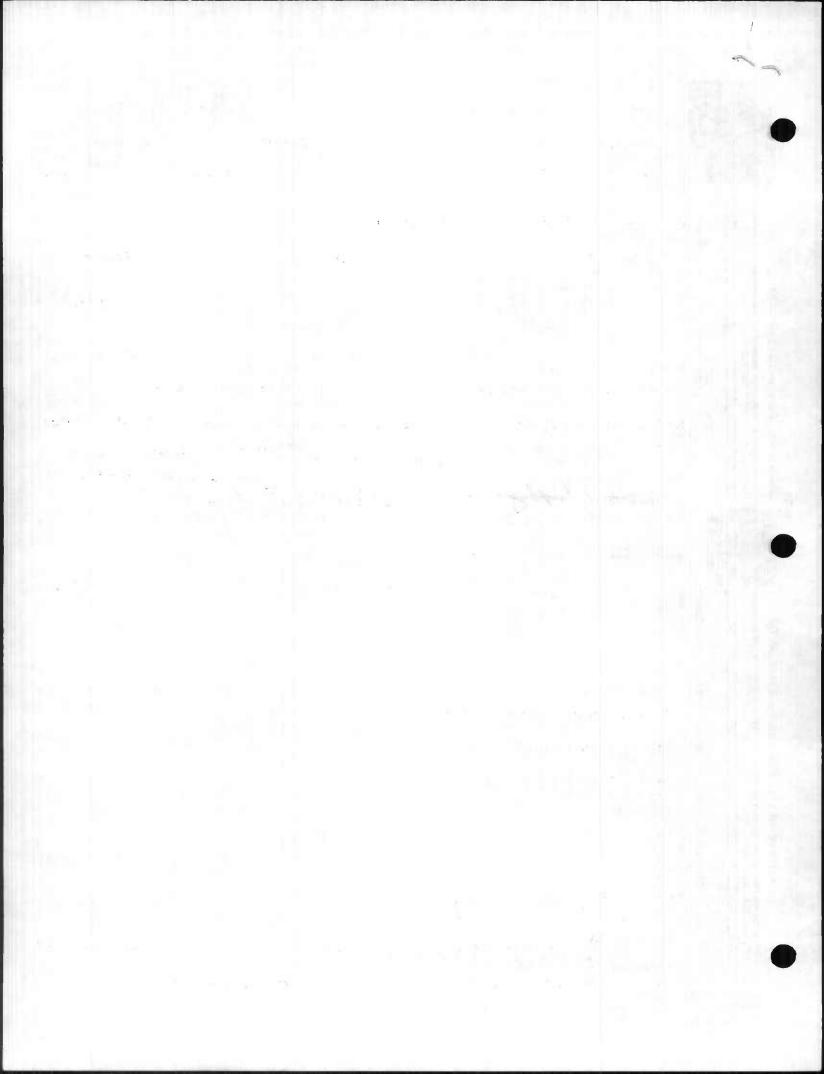
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	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate interval Between Onset and Death												te					
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cian/Medical Examir	resulting in death)	Last	d															
Physician/M			<u> </u>										- 53					
Sic	Pert II. Other sign	ficant condition	s contributing	to death but n	ot resulting In	the underly	ying ceuse g	iven in Pert I.	23b. Die	tobacco use c	ontributa to t	the causa	of death					
F.									1 Yes 2 No 3 Probably 4			bly 4] Unknov					
by											1							
ted									24e. We per	s an eutopsy formed?	avai	e eutopsy lebie prior	to					
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certificate hes been s ractor, page 2 should Be Completed	25 Mac coco roto	rred to medicel						26. Place of I	Deeth (Check only	one)								
0		No	Hospitel:	1 Inpatient	2□ ER/Ou	tpetient 3	DOA O	ther: 4 Nursin	Home 5 Re	sidence 6 🗆 O	ther (Specify)							
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onatary miled in by the funeral of actor. edical Certification: To Be	examiner? 1 Yes 2 27. Menner of Dee 1 Acident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and 30. Name and add	th 5 Pending investigs 6 Could not determine 1 Certifying 2 Medical E	physician: Tixeminer: On the end	o the best of menner stated	y knowledge minetion end	, death occidor Investig	urred et the pation, in my	opinion, deeth o	ece, end due to the	e ceuse(s) end r e, date end plece 29d. Dete sign	e, end due to the ned (Month, D	ey, Year)	999					



State of Maryland / Department of Health and Mental Hygiene Q Q

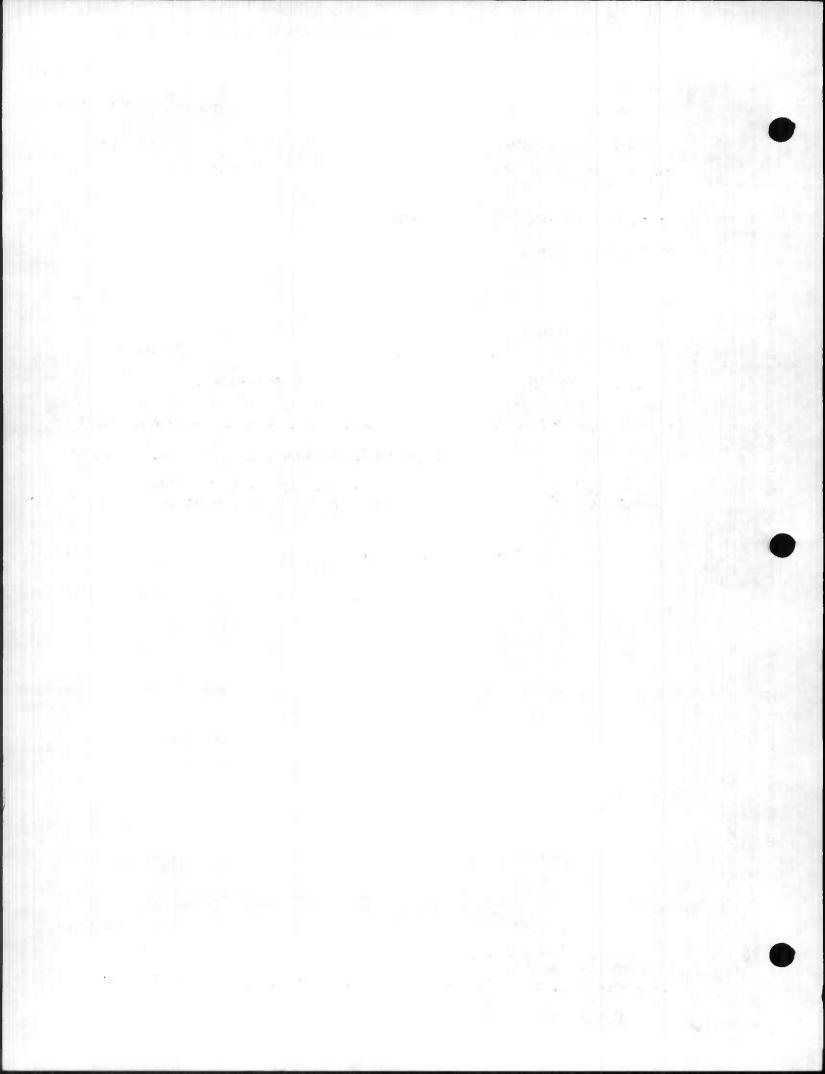
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey **Physician** James Patrick McMahon, Jr. February 24, 1999 6:30PM /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Rockville Nursing Home Rockville Montgomery If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Dey, Year) If Under 1 Yeer 5. Sociel Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthdey) **Funeral** 10 M 2□ F Months Deys Yrs. 68 578-34-1389 **Director** March 16, 1930 Rhode Island Usual Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Modical Examinar man be notified at 1 XYes 2 No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 802 Lyon Place 20851 United States Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "naturel", or then any injury or other traumatic event, tra Mexical Examinat. 1 ☐ Yes 2 No It Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: þ 3 Nidowed 4 Divorced White Completed 16e. Decedent's Usuel Occupetion 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) 4 Insurance Broker Insurance 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Patrick McMahon, Sr. Clara Francis McConnell 19a. Intorment's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Paul C. McMahon / son 1816 Millstream Drive, Frederick, Maryland 21702 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) March 1, 1999 20e. Method of Disposition 20c. Location - City or Town, State 1 XBuriel 2 ☐ Cremetion 3 ☐ Removel from Stete Rockville, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Mary's Cemetery 22. Name end Address of Fecility Robert A. Pumphrey Funeral Home / 21. Signeture of Funeral Service Ligensee Mulliam A. Fulliphrey Funeral Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Stroke 3 Days **Examiner** Due to (or as a consequence ot): Examiner Cerebral Arteriosclerosis 10 Years certificate be executed physicien and s the burief-trans Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760 Physiclan/Medical Due to (or es e consequence of) 80 esn Po Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? P. signed by 1 | Yes 2 | No 3 | Probably 4 | Unknown Senile dementia (multi infarct) Division of Vital Records, þ 24a. Wes en eutopsy performed? Completed 24b. Were autopsy tindings evallable prior to peen Cancer skin (cheek) completion of cause of deeth? hes 1 ☐ Yes 2 ☒ No Coronary Artery Disease director Be 25. Was case reterred to medical exeminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify) 10 1 Tyes 2 Tx No After this 28e. Dete of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: or Attending 1 Natural 5 Pending s efter death. investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 2 4 Homicide filled in To the Hospital of within 24 hours of To the Funeral D 29a. Certifier 1 🔀 Certifying Physician: To the best 🚀 knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner es stated. Medical nor: On the basis of and manner of (Check only mination and/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) onel 29b. Signature and Nije of centile 29c. License number 29d. Date signed (Month, Dey, Year) D07471 February 25, 1999 or coath (Item 23a) (Type, Print) wie 30. Neme and eddress of erson who completed Paul T. Noone, M.D. 50 W. Edmonston Drive, Rockville, MD 20852 31. Dete filed (Month, Day, Year) 32. Fleightur's Signeture 1999 MAR 02 Registrar

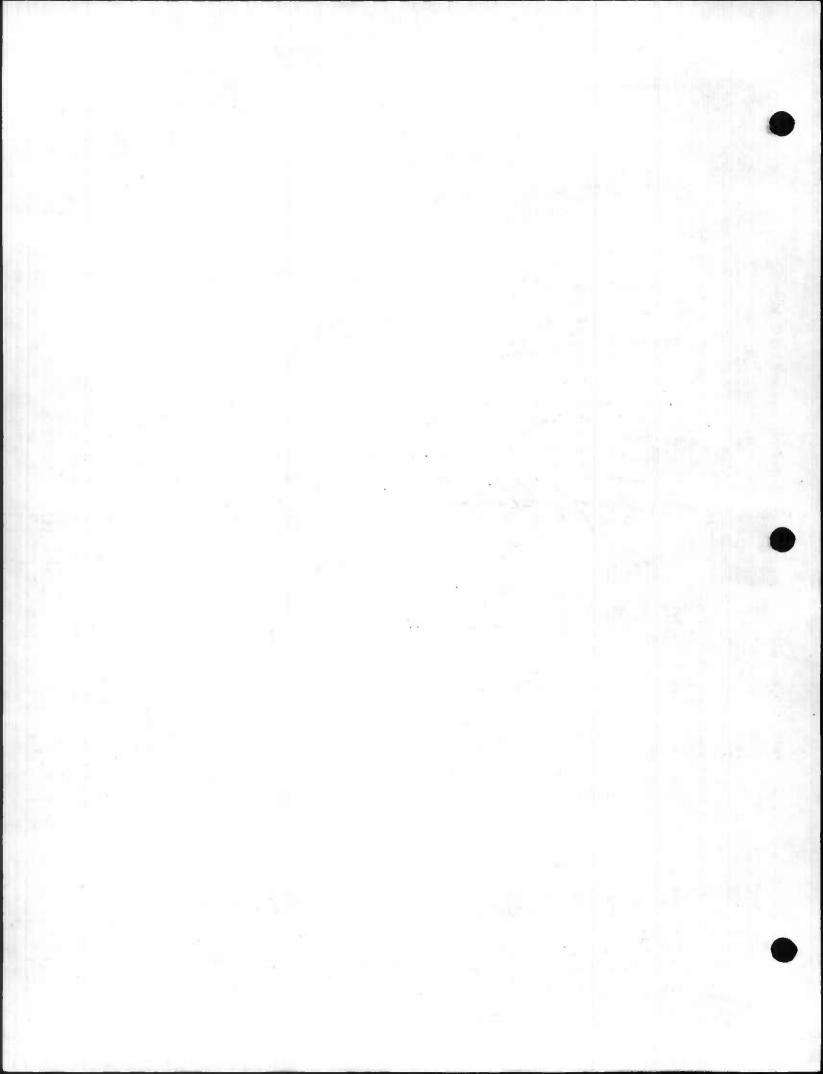


State of Maryland / Department of Health and Mental Hygiene

				Certifica	te of	Death			Reg. No.	3 0	69		
	1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Day Yes									Vac-	3. Tim	ne of Death	
ysician Jedical	Ellen Salomon	Malaskv						Month Februa	ry 24,	1999	5:2	23 am	
dicai niner	4a Facility Name (If not institution, g					4b. City, To	wn, or Lo	cation of Death	-	nty of Deeth			
	9204 REDWOOD A	A ZEINIT IEI				BETH	TCDA		MONT	IGOMEI	RV		
			(In yrs. last b		er 1 Year	if Under	24 Hrs.	8. Dete of Bir	th	9. Birth	place (St	ate or Foreign	
	200.34.3774	1□ M 2QF	55	Yrs. Month	Deys	Hours	Min.	08.12.	1943	Cou		PA	
	Usuai Residence of Decedent		32.3	2									
	10e. State 10b. County		10c. City, Tov	vn or Location							10d. Insid	de City Limits	
to	MARYLAND MONTGON	ŒRY	BETHES	SDA							10	Yes 2 No	
Director	10e. Street end Number			10f. 2	ip Code				10g. Citizen of Whet Country?				
	9204 REDWOOD AVE	ENUE		2	0817	,			USA				
Funeral	11. Marital Status	12. Was Decedent I	Ever in U,S.	13. Wes Dec	edent of	of Hispenic Origin? (Specify Yes or No- Cuban, Mexican, Puerto Rican, etc.)			- 14. R	ace - Ameri		n,	
Fu	1 Never Merried 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ N	lo				, Puerto I	Hican, etc.)	В	leck, White,	, etc.		
Š	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give A Year or Dates:		1 ☐ Yes	2 No	Specify:			Spec	ity: WI	HITE		
	15. Decedent's I		168	. Decedent's Us	uai Occu	pation		Jacob III	16b. Kind of	Business/Ir	ndustry		
pie	(Specify only highest g			(Give kind of v life. DO NOT	vork done use retire	during mosi ed)	t of workii	ng					
Completed	Elementery/Secondary (0-12)	College (1-4or 5	+)	TEACHER	ER EDUCAT:					TION			
	17. Fether's Neme (First, Middle, Las	Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)							ame)				
To Be	LAZARUS M. SALO	LAZARUS M. SALOMON LORE LEWKOWITZ											
-	19e. Informent's Neme/Reletionship	(Tyne Print)	19	h Meiling Addre	ss (Stree	t end Numbe	er or Rura	i Route Numb	er. City or Tox	m State Zi	in Code)		
any injury or other trac			And the second s								817		
	ALAN R. MALASKY, 20a, Method of Disposition	HUSBAND		of Disposition (A		AVE,	DETIN	Date Date	20c. Locatio			ie	
	1 Buriel 2 Cremation 3 Removel from State cemetery, crematory or other place)												
	4 Donetion 5 Other (Spec		JUDEA				_ t	. 20.99	OLINEI,	MAINI	TIMIN		
	21. Signature of Funeral Service Lin	10 800				ess of Fecilit		AL DIRE	CULTUM	TNC			
	Gull							E, ROCK			LAND	20852	
	23a. Part1. Enter the diseese, or co- shock, or heart failure. List onl	mplications that caused	the deeth. Do								Approx		
cian	Shock, of fleat failule. List off	y one cause on each in	10.								Onset	and Deeth	
	immediate Ceuse (Final disease or condition METASTIC LUNG CANCER										2 Y	EARS	
	resulting in deeth)	0.		consequence o	6)-								
Jer			Due to (01 es e	consequence o	1).								
Examine	Construction that are divined	b	Due to for es e	consequence	n.								
Exa	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	Due to (or es e consequence of)								1			
	Ceuse (Disease or Injury that initieted events	C	Dua to for on a	consequence of	P. o								
edical	resulting in deeth) Lest		Due to (or as e	consequence of):								
2		■ d											
ciar													
Physician/	Pert II. Other significant conditions	contributing to death bu	it not resulting	in the underlying	cause g	iven In Pert I						use of death?	
								1 🗆	Yes 2 N) 3□ Pro	obably	4⊠ Unknown	
2													
combiered									en eutopsy ormed?	9	veileble p		
3											ompletion of deeth?	n of cause	
								10	Yes 20 No	1	Yes	2 No	
	25. Was case referred to medical		·			26. Plece	ot Deeth	(Check only					
o Be	examiner? 1 ☐ Yes 2 ☒ No	Hospitel:	rit 2 ER/O	utpatient 3 :	DOA O	ther:		me 512 Resi		Other (Sner	cify)		
n: To	27. Menner of Deeth	28e. Dete of Injur	v 28b.	Time of	28c. Inje			28d. Describe			}/		
Certification:	1 ⊠Neturel 5 ☐ Pending 2 ☐ Accident investigati	(Month, De)	(Tear)	Injury M		ork?]Yes 2.∐	No						
2	3 Suicide 6 Could not	be Diese of Init	ry - At home. f					28f. Location (Street end Nu	mber or Ru	rel Route	Number,	
5	4 ☐ Homicide determine	building, etc	(Specify)	, 5551, 1001	,,				wn, State)				
	29e. Certifier 1 Certifying F	hyelologe To the back	of my bounded	n doeth seeme	od as shore	imo data r-	d place	and due to the	consolet and	mana	etatad		
edicai		hysician: To the best of miner: On the besis of	examinetion e									use(s)	
Med		end menner sta	iled.	- 1	Se Lines	na number	_		20d Date sin	nad (Month	Day Ve	and .	
	29b. Signature and title of certifier	1/1 1/				ise number			29d. Date sig	The State of	, way, Til		
	1 //4	Tull			D33	293			02.24.	1999			
	30. Neme and eddress of person who	completed cause of de	eath (Item 23e)	(Type, Print)									
	Frederick P. Sm	ith, M'D"	5401 W	estern	Ave.	NW. W	lashi	ng6ton	, D.C.	20015	;		
to	31. Dete filed (Month, Day, Year)		er's Signeture	/	1	4							
itate strar	2220 A 1 10		war	D. A.	oach	2/							

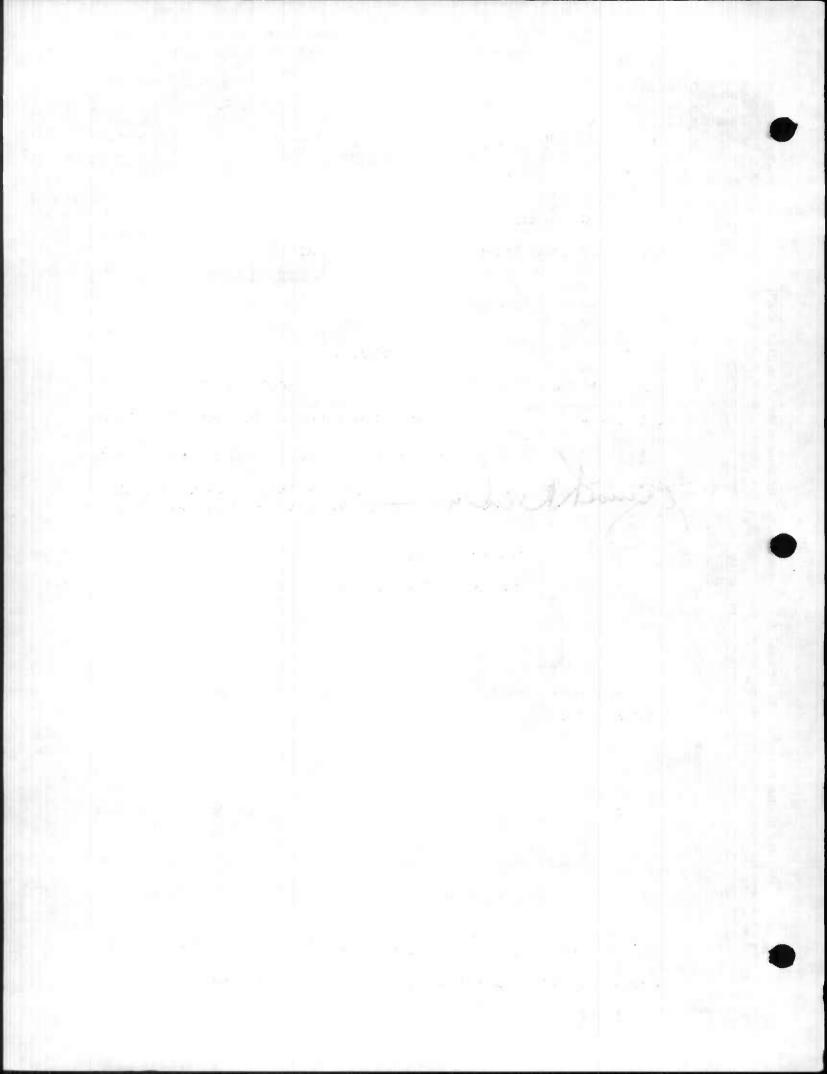


		Decedent's Nama (First, Middle,	Last)	C	ertificate of	Death	2. Data of Dea	Reg. No.	1 :	3. Time of Death		
	Physician	ANASTASIA	The second secon	MAC	CHARIA		Month	Day	Year	10:14AM		
S	/Medical Examiner	4a Facility Nama (If not institution,		1111		4b. City, Town, or L	MARCH ocation of Death			TO. TANK		
7	LAGITITIES	MONTGOMERY	GENERAL	HOSPITAL		OLNEY		MONT	GOMER'	Y		
	Funeral Director			a (In yrs. last birthda 39 Yrs.	y) If Under 1 Yaar		8. Data of Birth (Month, Day JAN.	13,196	9. Birthplac Country)	a (State or Foreign NYA		
	2 >	Usual Rasidence of Decedent		10- 0h: T								
	e Maryla Ba-f show office a	MD 10b. County MONTG	OMERY	10c. City, Town or SILVER				Inside City Limits 1 Yes 2 No				
	ifter death with the Maryland r Nema 23a or 28a-f show near must be notified at Funeral Director	10e. Street and Number 13403 BRIAR P	ATH LANE		10f. Zip Code 2 0 !	906		10g. Citizen of V USA	What Country	?		
	urs after at, or its frame by Fui	11. Marital Status 1 Navar Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forcas? 1 Yas 2 If Yas, Giva Year or Datas:	Evar in U,S. 1	3. Was Decedent of I If Yas, apecify Cub		ecify Yas or No- Rican, atc.)	14. Rac Blac Specify	e - American ck, Whita, etc.	Tal.		
5-0	72 ho	15. Decedent's (Specify only highest	Education grade completed)	16a. De	cedent's Usual Occur ve kind of work done	pation during most of work	ina	16b. Kind of Br	usiness/Indus	try		
21215-0020		Elementary/Secondary (0-12)	College (1-4or 5	lite	ATTORNE	id)						
9	be filed d other avent, n Be Cc	17. Fathar's Nama (First, Middla, La				18. Mother's Nam	a (First, Middle,	Maiden Surnan	10)			
<u>X</u>		NGANGA MACHA	I									
=	. Pages 1 and 2 ment of Health a tent: If item 27 is jury or other tra	19a. Informant's Name/Reletionshi		Route Number, City or Town, State, Zip Code) NE, SIL SPR. MD. 20906								
altimore,		20a. Mathod of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		cemetery, c	position (Name of remetory or other place RIA GROU		Data / 9 / 9 9	20c. Location -				
Balti		21. Signature of Emeral Service Li	oensee /	1	22. Nama end Addra AUSTIN R 3821 141	ass of Facility	FUNERAI					
0		23a Part Folor the dingers or o	unnlications that cause	I the death Do got					2001	proximete		
	lhualaian	23a. Part 1. Enter the disease, or a shock, or heart fallure. List be	nly one cause on each li	na.	ontar the mode of dy	rig, sour as our diac	or respiratory ar	iuot,	Int	terval Between		
	Physician /Medical	Immediata Causa (Floral	Penn	-n km. i	0 0					٨		
	Examiner	disaasa or condition rasulting in death) Due to (or as a consequence of):										
	ě		It en	a hi C	Ci. Puro				110	nonte		
	n and fightransit	Sequentially list conditions,	Ь.	Due to (or as a cons	sequenca of):			-		TO TO TO		
SC,	orien suriel	Sequantially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated evants	Hepa	toma					12	years		
68/60,	incale be executed g physician and as the buris-transit ledical Examir	rasulting in death) Last										
XO	endin r use		d				_		1			
	s dear he att	Part II. Other significant conditions	s contributing to death be	ut not resulting in the	underlying cause gi	ven in Pert I.	23b. Did t	obacco use co	ntribute to th	e cause of death?		
, P.O. Box	es that the death certing one of the attending be detached for use a by Physician/M	7 1					101	res 2□ No	3 Probeb	ly 4 Unknow		
Division of Vital Records,	been s should						24a. Wes perfor	an eutopsy med?	availa	autopsy findings ble prior to letion of cause ith?		
ř	te hes						1 🗆 Y	as 2 No		as A No		
ā		25. Was casa rafarred to medical				26. Place of Deel	th (Check only o		1	^		
> :	this ce all direct	axaminar? 1 ☐ Yas 2/X No	Hospital:	nt 2 ER/Outpat	ient 3 DOA Ot	her: 4 Nursing Ho	oma 5 🗆 Flasid	lence 6 Oth	er (Specify)			
0 00	ther the rection of t	27. Mannar of Death 1	28a. Data of Inju (Month, Da)		/ Wo	ry at vrk?] Yes 2 ☐ No	28d. Describe h	low injury occur	red	7-0		
DIVIS	as or attending in a ster death. al Director: After the linby the funeral Certification:	3 Suicide 6 Could no 4 Homicide determin	28a. Place of Injuding, ato		street, factory, office		28f. Location (S City or Tow		per or Rural R	oute Number,		
:	urb negletal or Arandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu Medical Certificati	29a. Certifiar (Check only one) Certifying (Medical Expone)	Physician: To the best of saminer; On the basis of and mannar sta	axamination and/or	eth occurred at the ti investigation, in my	ma, date and place, opinion, death occur	end due to the o	cause(s) and ma data and placa,	anner as state and due to th	ed. e cause(s)		
1	Me the	29b. Signatura and titla of certifiar			29c. Licans			29d. Data signe				
	O	Amend	0112 @ 00	a hin	038	262		Mard	1/81/	999		
	2	30. Nama and addrass of person w	1	^	e, Print)	ive Su	A Din		A . C	2 2 2 3		
		31. Date filed (Month, Day, Year)		VVINCE I	hilip Dr	The Su	le 212	Olne	4 MD	10832		
	State Registrar	WAR 0 4 19		va G.	South							



State of Maryland / Department of Health and Mental Hygiene	9	0	
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	State of Maryland / Department of Health and Certificate of Death		gieneg g	08513							
Physicia /Medic	HELEN MANN	2. Dete of Dee Month FEB 26	Day	3. Time of Death 2:00AM							
Examine	An English Name (Mant in this in the standard or developed)		4c. County of								
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 1 Under 1 Year If Under 24 Hrs. 577-58-3073 1 M 2 F 91 Yrs. Montha Deys Hours Min.	8. Date of Birth (Month, Day JAN 2	1, 1908	9. Birthplece (State or Foreign POLAND							
and and	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits							
Mary	MD MONTGOMERY ROCKVILLE			1 ☐ Yes 27 No							
death with the Manjand me 23a or 28a-f show f must be notified at	MD MONTGOMERY ROCKVILLE 10e. Street end Number 1801 E. JEFFERSON STREET #331 1. Maritel Stetus 1. Maritel Stetus 1. Never Married 2. Married 1. Yes 25 No 1. Never Married 2. Married 2. Married 1. Yes 25 No 20852		10g. Citizen of Wh	net Country? USA							
020 urs after pf., or its	3 Widowed 4 □ Divorced If Yes, Give 1 1 □ Yes 2 1 No Specify:	specify Yes or No- to Rican, etc.)	Black	- American Indian, White, etc. WHITE							
vithin 72 he ane. than "natur	15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) 12 16e. Decedent's Usuel Occupation (Give kind of work done during most of work life. DO NOT use retired) SALESPERSON	rking	16b. Kind of Bus								
be file to othe event.	17. Fether's Name (First, Middle, Last) ASHER BEIGON SARAH	<i>Maiden Sum</i> eme G)								
2 2 2 2	19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Re	19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Ste									
Baltimore, N permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr	20a. Method of Disposition 1 Buriel 2 Cremetion Removal from State 4 Donation 5 Other (Specify)	Dete ./28/99 W		N D.C.							
Balt permit. Depart Importu	21. Squature of Funeral Simple successee 22. Name end Address of Fecility DANZANSKY-GOLDBERG 1170 ROCKVILLE PIK 23a. Parti. Enthrithe disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardial shock, or heart failure. List only one cause on each line.	E ROCKVI	LLE. MD								
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) CARDIOPULMONARY ARREST										
	Due to (or es e consequenca ot): CORONARY ARTERY DISEASE			20 YEARS							
	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of):										
BOX death cert eath cert of for use	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Dtd t	obacco use cont	ribute to the cause of death?							
P.O hat the d by th	d Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS	23b. Did tobacco use contribute to the cause of 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ U									
aw requir		24a. Was o	en eutopsy med?	24b. Were eutopsy findings eveileble prior to completion of cause of deeth?							
al Rec		1 🗆 Y	es 2⊠No	1 Yes 2 No							
of Vital Physician: This cartificate and director, pe	examiner?	eth (Check only of		(Spacify)							
Division of Vital Re to the Hospital or Attanding Physician: The is within 24 hours after death. To the Funeral Director: After this carificate ha completely filled in by the funeral director, page	The imparient and the imparient of the i	1	now Injury occurre								
Division bal or Attend s after death al Director: A ed in by the f	27. Menner of Deeth 1 Naturel 5 Pending 28e. Dete of Injury 28e. Time of Injury	Street end Number n, Stete)	r or Rural Route Number,								
To the Hospital Within 24 hours To the Funeral completely filled	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plect (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plect (Check only one) 2 Medicat Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end plect (Check only one)	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) and manner as stated. (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) and manner as stated.									
To the vithin To the comple	29b. Signature end title of certifier 29c. License number DC 14398		29d. Dete signed B. 26, 1	(Month, Day, Year)							
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) LAWRENCE E. KLEIN, MD 3301 NEW MEXICO AVE NW WASHINGT	ON DC 20	016								
Stat Registra	31. Dete tiled (Month, Day, Year) 32. Registrer's Signeture										



State Registrar 31. Date filed (Month, Dey, Year) 1999 MAR 01

29b. Signeture and title of certifier

Suresh A.

32. Registrer's Signeture

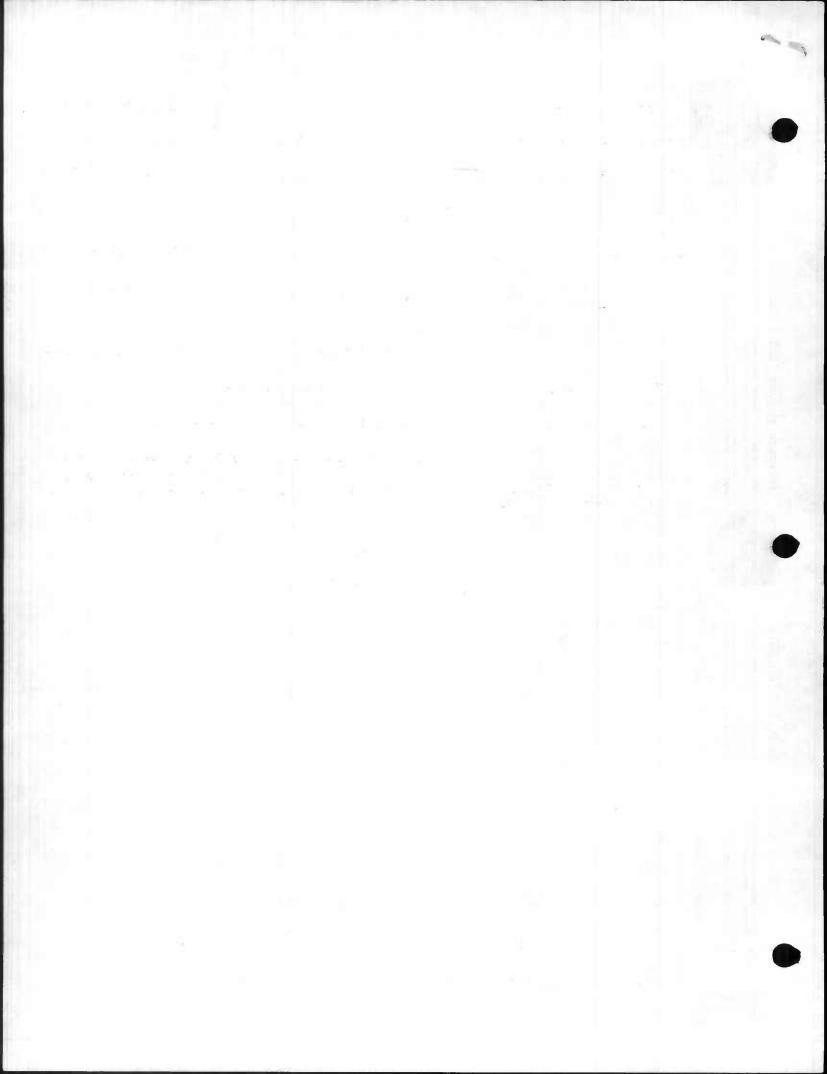
30. Neme end address of person who compléted cause of deeth (Item 23e) (Type, Print) Patel-M.D

7501 Syrratts Rd # 307. Clinton mD 20735

29c. License number

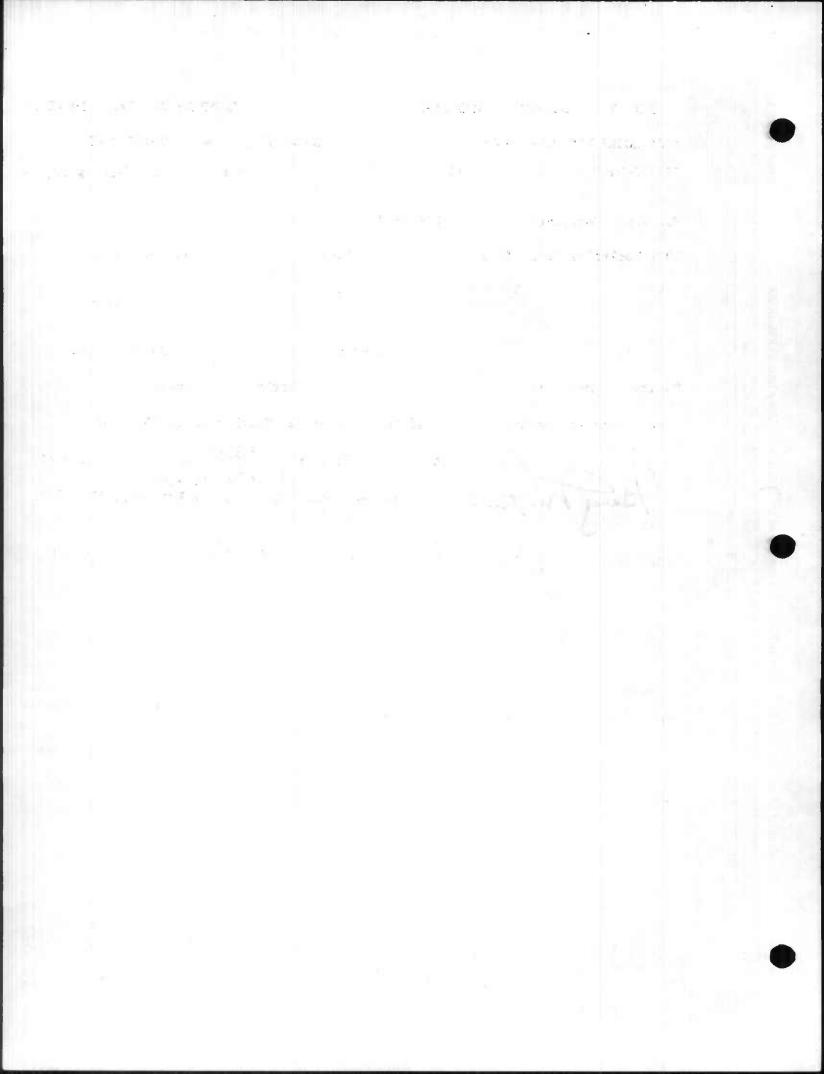
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29d. Date signed (Month, Day, Year)



State of Maryland	Department of H	Health and Mental Hygiene	0

				Certificate	of	Death		В	leg. No.			
	1. Decedent's Name (First, Midd	le, Last)					2	Dete of Dea	th Dev	Vaar	3. Time o	of Deeth
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/Medical Examiner	4a Facility Neme (If not institutio					4b. City, To		tion of Deeth	4c. Count			
Examine	1001 ROCKVILLE	DTVF #615				ROCKV	TLLE		MONT	IGOME	PΥ	
	5. Social Security Number		Age (In yrs. last birth	day) If Undar 1				Date of Birth (Month, Dey			leca (Stete	or Foreign
Funeral Director	578-07-8449	1 M 2□ F	74 Y	Months	Days	Hours	Min.	(Month, Dey April 7	, Year)	Wash	inoto	n. De
JIICCIOI	Usuel Residence of Decedent							ipili /	, 1727	Nasii	111500	11, 0
ž 11	10a. State 10b. County		10c. City, Town	or Location						1	0d. Inside (City Limits
or sh	Manual and Mante		Rocky	-1110							1 ₽ Ye	s 2 No
be notified Director	Maryland Mont	gomery	ROCK	10f. Zip 0	'odo				log. Citizen of	What Cour	tru?	
'neturel', or items 23a or 28a-f show edical Examiner must be notified at leted by Funeral Director												
ra 1 23	1001 Rockville	-			085				United			
doer must	11. Merital Status	12. Was Deceder Armed Forces		Wes Decede If Yas, specif	dent of Hispanic Origin? (Specify Yes or No- cify Cuben, Mexican, Puerto Rican, etc.)			14. He	ce - Americ ck, White,			
图 正	1 Nevar Married 2 Mar	ried 1 X Yes 2 If Yes, Give] No	1 ☐ Yes 2					Specia	<i>₩</i> -		
by	3 ☐ Widowed 4 ☐ Divorced	Yaar or Detes	: WWII		21				Opean	whi	te	
Completed	15. Deceder	nt's Education	16e. D	ecedent's Usuel	Occup	pation	t of working	,	16b. Kind of B	Jusiness/Inc	Justry	
ple	Elementery/Secondery (0-12)	st grede completed) College (1-4o	(54)	Give kind of work ife. DO NOT use	retire	d)	or working					
E	12	Conege (1-40	1 34)	Painte	r				Cons	struct	ion	
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Be	Donato Mar	raffa				Ma	ria		Luizzi			
70			105.1	Antina Address (Ctrool					Ctoto Zin	Codel	
	19e. Informent's Name/Relations			Mailing Address (
To Be Comp	Henry Marraffa	, Nephew		Keyston		rive,	Gait			2087		
	20a. Method of Disposition 1 ☐ Burjul 2 ☒ Cremetion	2 Domoval from State	nometer.	Disposition (Name cremetory or oth		ice)	Ма	Dete	20c. Location	- City or To	wn, Stete	
	4 Denation 5 Other (S			olitan C	ren	natory			Alexano	dria,	Virg:	inia
d	21. Signature of Funeral Service	Licenses	-	22. Neme and					neral H			
once.	140	To (4		10 5	D -	D .					m 20	2077
	Jakey 1	M. The	i	10 East						irg, r		0877
	23e. Pentl. Enter the disease, or shock, or heart failure List	r complications that caus t only one cause on each	line.	t enter the mode	or ayı	ng, such es	cerdiac or i	respiretory an	rast,	1	Approxime Intervel Be Onset end	neewte
an	0		1	1.		1	1.			1	Oriset enc	Doon
al	Immediate Ceuse (Finel diseese or condition	Ather	asclero	tic h	ea	rt	dist	ease		į	4ea	'NS
er	resulting in death)	0. 111111	Due to (or es e co	1,							1	
ner												
Examiner	Sequentially list conditions	b	Due to (or es e co	nsequence of):								
X	Sequantielly list conditions, if eny, leeding to immediate cause. Enter Underlying											
· m	cause. Enter Underlying Ceuse (Disease or injury that initiated events	c	B = 1 = (
cian/Medicai Examir	resulting In death) Lest		Due to (or es e co	nsequence on:						1		
₹		d										
Physician										1		
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by	TURIMELL	MT DIOC	dy al	017718	4				/			
			1					24a. Wes	en eutopsy	24b. W	ere eutopsy eileble prior	findings
Completed								репо	med?	co	mpletion of deeth?	
ם									1/			1
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Be	25. Wes cese referred to medice examiner?				10		of Deeth (Check only o	ne)			
To Be Com	1 Yes 2□ No	Hospital: 1 Inpa	tien1 2 ER/Outp	patient 3 DOA	1		ursing Home	/	lance 6 DOt		y)	
=	27. Manner of Deeth 1. Naturel 5 ☐ Pendii	28e. Dete of In	njury 28b. Tir	na of 28 ury	c. Inju Wo	ry at	28	d. Describe h	ow injury occu	rred		
Certification:		igation		М		Yes 2	No					
3	3 ☐ Suicida 6 ☐ Could	nined 286. Piece of	Injury - At home, fam	n, street, factory,	office		28		Street end Num	ber or Rure	Aouta Nu	mber,
ert	4 Homicide	building,	etc. (Specify)					City or Tow	n, Stete)			
	29a, Certifier 1□ Certifyin	na Obvelsian. To the hor	at of my knowledge	dooth occurred of	thoti	ima data an	d place on	ed due to the c	nouse(s) and m	0.00001.00.0	tated	
edicai	(Check only 2 Medicai		of examinetion end/									(s)
_	29b. Signature and title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Yaer)										1900	
	Partucia 2	· Jomski	7 1100		US	17/6	2	1	epru	ary	20,1	17/
	3Q. Name end eddress of person	who completed ceuse of	f death (Item 23a) (T	ype, Prigit)	/	10.1	#.	in h	1 .	11/ 11	1 D	2.6
	Patricia / T.	omsto. Mh	11140 k	ockvill	e	Pike.	734	8, Ko	KVIL	10,11	10 2	085
tota	31. Dete filed (Month, Day, Year,	32. Res	strer's Signeture	1. 1				/	,,	-/		- 5
State	1170 0 1	1000 1	Lesson !	19 10	Ba I	1						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Month Day MASCARI 13:00 FEBRUARY 26 1999 1 HOMAS 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street and number) 4c. County of Death BALTIMORE CITY

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Pay, Year)
Feb. 4, 1960 JOHNS HOPKINS

5. Social Security Number HOSPITAL N/A 6. Sax 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 12 M 2 F New York 217-76-1988 Yrs. 39 Usual Residence of Decedent 10e. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Germantown Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20874 USA 13303 Waterside Circle 12. Wes Decedent Ever In U.S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indian Bleck, White, etc. 1 X Never Married 2 ☐ Married White 1 ☐ Yes 2 ☒ No Specify: 3 Widowed 4 Divorcad 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) Elamantary/Secondary (0-12) College (1-4or 5+) Cleaning Service 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maidan Sumame) Patricia Weekes Robert F. Mascari 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 15312 Narcissus Way, Rockville, MD 20853 Patricia W. Mascari/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 3/2/99 Silver Spring, MD Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., West 21. Signature of Funeral Servica Licensee Home, Inc. Samo Silver Spring, MD 20901 Approximete 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. terval Batween Onset and Death Immediate Cause (Final disease or condition rasulting in death) . MULTI- SYSTEM URGAN FAILURE DAYS Due to (or es a consequence of): DAYS OVERWHELMING SEPSIS Sequantially list conditions, if any, leading to immadiata cause. Enter Undarlying Causa (Disaasa or Injury that initiated evants resulting in death) Last Due to (or es a consequence of): Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacço use contribute to the cause of death? No No 3 Probably 4 Unknown 1 Yes ROHN'S DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed' 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mannar of Daath 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred

Physician /Medical Examiner

permit. Pege Depertment of Important: If any injury or page.

Physician

/Medical

Examiner

MD

Director

Funeral

ò

Completed

Be

Funeral

Director

Peges 1 and 2 should be filed within 72 hours efter death with the Menyland nent of Health and Mental Hygiene. Intil if Item 27 Is marked other than "neturel", or items 23s or 23s-f ehow any or other transmit or each, the Mental Last notified at my or other transmits event, the Mental Last notified at

Baltimore, Maryland 21215-0020

Examiner ettending physician and for use es the buriel-transit Physician/Medical been signed by the should be deteched þ Completed

P.O. Box 68760

Division of Vital Records,

certificete hes b lirector, page 2 s director this funeral After after deeth. Director: Al n 24 hours after dec Ne Funeral Director eletely filled in by the

Be

To.

Certification:

edicai

State

Registra

The law requires that the death certificate be executed Physician; or Attending

completely To the Within 2 To the

Hospital

6 Could not be datermined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifia (Check only one) 29b. Signatura and titla of cartifier 29c. License number 29d. Date signed (Month, Day, Year) FEBRUARY 26, 1999 30. Name and address of person who completed cause of death (Item 23a) (Typa, Print)

KICHARD S 31. Data filed (Month, Day, Year) MAR 01

1 Natural
2 Accident

5 Panding Invastigation

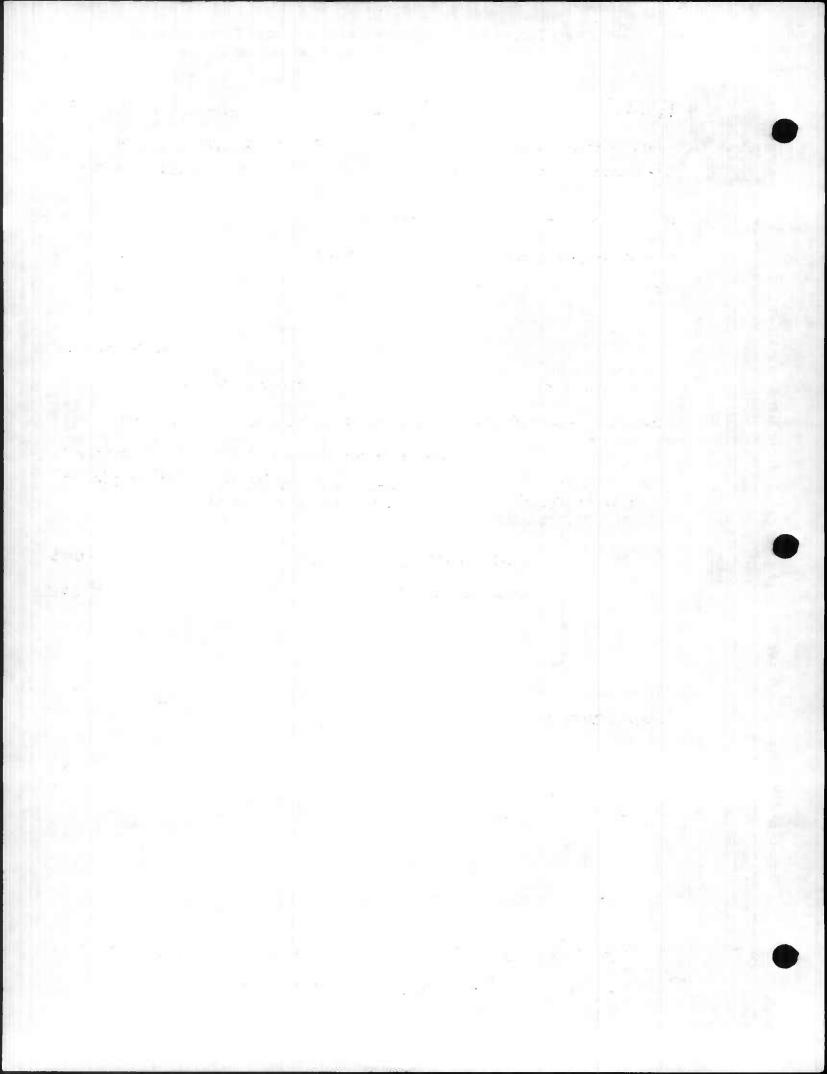
VAX, M.D

MORTON 32. Registrar's Signature

BALTIMORE, MO

1 Yes 2 No

2120



	-1010 01 1110	y latia /			of Death		Mental Hyg	eg. No.	9 118	517
1. Decedent's Neme (First, Middle, Las	st)						2. Deta of Deetl Month		Yeer 3. 1	Time of Deeth
		Harry N	Meresm	an			March	3, 19		23 P. M
a. Fecility Nema (If not institution, give	street and number)				4b. City, To	wn, or Lo	ocation of Deeth	4c. County	y of Deeth	
Manorcare Social Sacurity Number 6. Se		//n to a 4 to	Cathoda N. W	Under 1 Y		omac	0.5		gomery	
	2 F 7. Age	(In yrs. lest t			Hours	Min.	8. Dete of Birth (Month, Day, January		Country)	Stete or Foreign York
0a. State 10b. County		10c. City, To	wn or Location	on					10d. In	sida City Limits
Maryland Montgo	mery	Potor	nac						X	Ŭ Yes 2□ No
0e. Street and Number			1	Of. Zip Co	da		10	og. Citizan of	What Country?	
10714 Potomac Te	nnis Lane			2085	54		U	nited :	States	
1. Marital Status	12. Was Decedant E Armed Forcas?	ver in U,S.	13. Was	Deceden	of Hispanic Ori	gin? (Sp	ecify Yas or No- Rican, atc.)		ce - Amarican Inc	dlen,
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ N If Yes, Give Year or Datas:	o		Yas 2		i, ruaito	riidaii, aic.		ck, White, atc. y: White	
15. Decedent's Ed (Specify only highast grad		16	e. Decadent	's Usual C	ccupetion	t of work	ina	6b. Kind of B	usiness/Industry	
Elamentary/Secondery (0-12)	College (1-4or 5-5+	+)			fone during mos etired) Public			Self-	Employe	i
7. Fether's Neme (First, Middle, Last)							e (First, Middla, N	faiden Sumen	ne)	
Joseph Meresman	1						binson			_
19a. Informant's Name/Ralationship (T							el Route Number,			
Helaine M. Barne	tt (Daug					New	York, N			
0e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☑	Removel from State	cemet	of Dispositio e <i>ry</i> , cremeto	ry or othe	r plece)	į	Date 2	Oc. Location	- City or Town, S	tete
4 ☐ Donetion 5 ☐ Other (Specify		Shar	on Gar			-	/5/99	Yahala	, New Yo	ork
21. Signeture of Funerel Servica Licans	tattle	us i			ddress of Facilit ky-Goldl ckville		Memoria e – Rock	l Chap	els, Ind	c. nd 20852
23a. Pert1. Entar the diseese, or comp shock, or heart failure. List only of	ellcetions thet cause	the deeth. Do							Appr	oximete vel Betwean
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mmediete Ceuse (Finel diseesa or condition	PA	0 R00	1001	A						
resulting in deeth)		Due to (or es e	Black a							
	b. 5	655	15						i I	
Sequentially list conditions, feny, leeding to immediate	_ '	Due to (or es a	consequen	ca of):						
cause. Enter Underlying Ceuse (Diseese or Injury	c	BH Sid	MU	A						
thet initieted events resulting in death) Lest	ď	Oue to (or es e	consequenc	ca of):						
ert II. Other significant conditions co	ntributing to death bu	t not resulting	in the under	tying caus	e given in Pert I		23b. Dld tol	acco uss co	ntribute to the	auss of death?
							1 □ Ye	s 2□ No	3 Probably	4 Unknown
							24e. Wes an perform		eveilable	on of cause
							1 □ Ye	s 2)0 No	1 ☐ Yes	2□ No
5. Wes case referred to medical exeminar?	Hospital:						(Check only one)		
10 163 2/410	Hospitel: 1 Inpatier			DOA		rsing Ho		nca 8 □Oth		
7. Manner of Deeth	28e. Dete of Injury (Month, Day	<i>Year)</i> 28b.	Time of Injury	28c.	Injury et Work? 1 ☐ Yes 2 ☐ I		28d. Describe hor	w injury occur	red	
1. Neturel 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be										

To the Hospital or Attending Physician: The law requires that the deeth cartificate be executed within 24 hours effer death.

To the Funeral Director: After this cartificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical

Examiner

To Be Completed by Funeral Director

Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, Ira Macinal Examiner must be notified at once.

Physician /Medical

Examiner

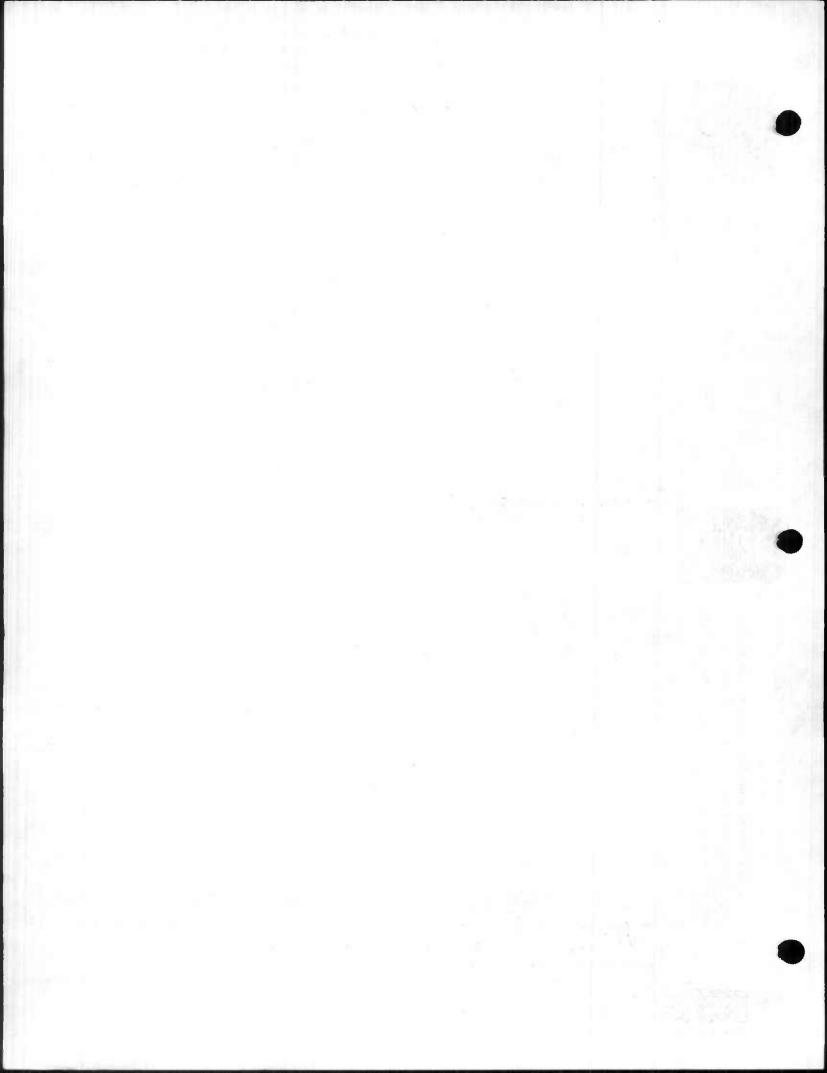
Baltimore, Maryland 21215-0020

MAR 0 5 1999



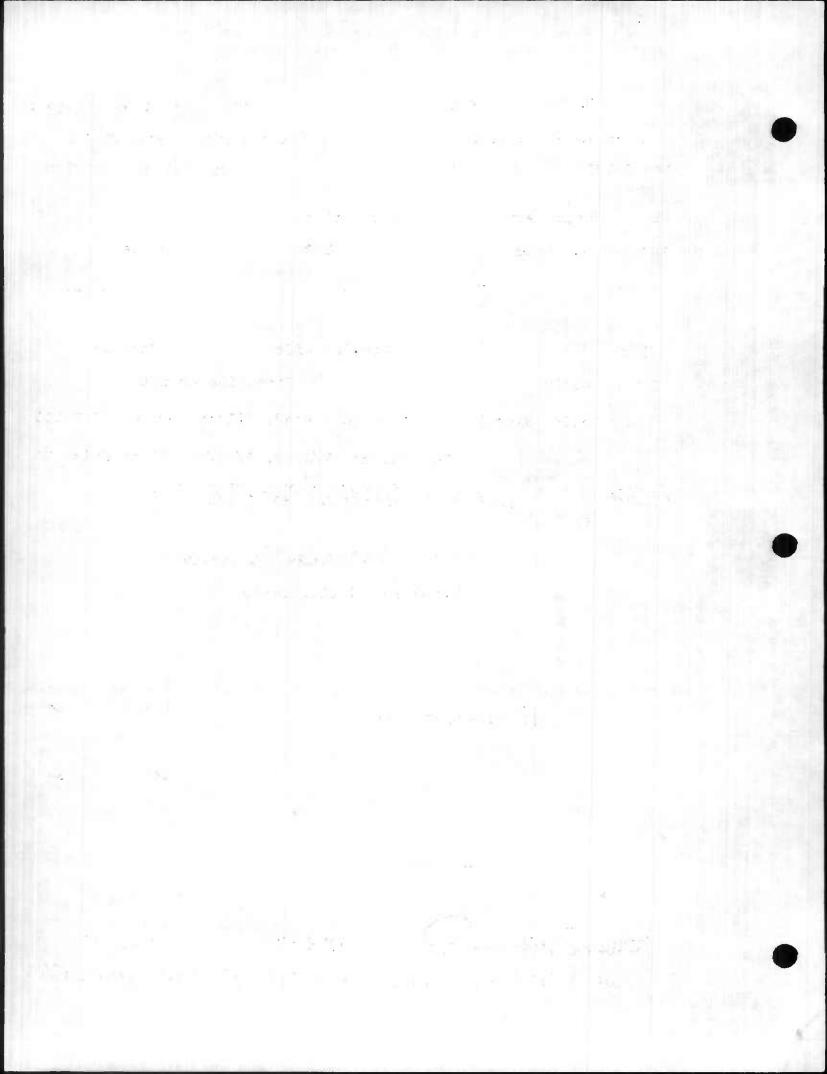
30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print)

H51280



State of Maryland / Department of Health and Mental Hygiene Q

				(Certificate of	Death		Reg. No.	085 8		
,	/sician ledical	Decedent's Name (First, Middle, L. BETTY		ER			2. Date of Dea Month FEB .	Day	Year 99 11:52 AM		
	aminer	4e Facility Name (If not institution, gi Medlantic of				4b. City, Town, or Silver	Location of Deeth				
Fune Direc			Sex 7. Age (In ye		day) If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birth (Month, De)	8,1921	9. Birthplace (State or Foreign Maryland		
, nd		Usuel Residence of Decedent	140-	Oh. Tour					and to the On the he		
aryla	-	MD Montqu			_{or Location} lver Spri	na			10d. Inside City Limits 1 ☐ Yes 2 🛣 No		
he M	ecto	10e. Street and Number	omery	SI.		119		1 ☐ Yes			
ath with 1	rai Dir	140 Norwood	Road			0905		U.S.	Α.		
21215-0020 d within 72 hours after death with the Maryland giene. rrthan "naturel", or frems 23a or 28s-f show	by Funeral Director	11. Maritel Status 1 Never Married 2 Married 3 Widowed ADivorced	12. Wes Decedent Evar in Armed Forces? 1 Yes ZZN No If Yes, Give Year or Dates:	d Forces? If Yes, specify Cuban, Mexican, Pue es 2%∑ No , Give 1 ☐ Yes 2 ☐ No Specify:			Specify Yes or No- to Rican, etc.)	Specify:	Americen Indien, k, White, etc. Black		
5-0 72 hx	Completed	15. Decedent's E (Specify only highest gr		1	Decedent's Usuel Occup Give kind of work done	during most of wa	orking	16b. Kind of Bu	siness/Industry		
	hpl	Eiementery/Secondary (0-12)	College (1-4or 5+)		life. DO NOT use retire	d)		Mod	lical		
offiled w	Be Comp	10th	43		Nursing	,	me (First, Middle,				
		17. Father's Name (First, Middle, Las Elwood Bodd)					ephine I		9)		
Maryla d 2 should th and Men 7 to marks	E P	19a. Informant's Name/Relationship	(Type, Print)		Malling Address (Street						
C = N +	t. Pages 1 an riment of Heal riant: If Nem 2 jury or other	Tracy Boddy					Silver	Spring	, MD 20905		
altimore, mit. Pages 1 ar partment of Hee		20a. Method of Disposition 1 Burial 2 Cremetion 3 Call Control Contro	THemovel Irom State		Disposition (Name of cremetory or other ple		Dete 2/27/9		City or Town, State		
Departr Imports	once.	22. Name end Address of Fecility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 23a. Part1. Enter the direction, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart facility. List only one ceuse on each line.									
68 /60, tificate be executed ig physician and effice the burdel fracet		Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that inkileted events resulting in death) Last	Duu to	(or as a co	onsequence of): Aes Me onsequence of): onsequence of):	llih	woml	109Y			
death cert e attending	ciar						001 014				
es that the death cer igned by the attendir	Physician/N	Part II. Other significant conditions	Parkm		1	ven in Part I.	23b. Did tobacco usa contribute to the cause of 1 Yes 2 No 3 Probably				
requir	eted a			730 74			24a. Was perio	an autopsy med?	24b. Were eutopsy findings evallable prior to completion of cause of death?		
The is	o B						101	res 2 No	1 Yes 2240		
sicien: The law certificate has be	Be C	25. Was case referred to medical				26. Place of De	ath (Check only o	ne)			
OT VITA Physician: this certific	U	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2	□ ER/Out	patient 3 DOA	her: Nursing	Home 5 ☐ Resid	denca 6 □Othe	er (Specify)		
After A	ion:	27. Menner of Death 1 Netural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Dey Year)	28b. Ti	ury Wo	ry at erk?] Yes 2 □ No	28d. Describe I	now injury occurr	ed		
DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After	Certification:	3 Suicide 6 Could not 4 Homlcide determined	28e. Placa of Injury - A building, etc. (Spe		m, street, fectory, office		28f. Location (S City or Tox		er or Rurel Route Number,		
Hospita 24 houn Funera	edical C		hysician: To the best of my k miner: On the besis of exami and manner states								
Takithir Tathir	W W	29b. Signature and title of cart 29c. License number 29d. Dete sign							ned (Month, Dey, Year)		
		30. Name end address of person who	PTA, M, D.	tem 23e) (1	ype, Print) Person	4 5+	M+.+	Ranier	, MD 20712		
Reg	State gistrar	31. Dete filed (Month, Day, Year) 19	32. Régistrar's Sk	nature	9. Spark	1					



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month March 2, Clarence E. Mills 1999 10:45am 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Shady Grove Adventist Nursing Center Rockville Montgomery If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) Days Months Hours 1♥M 2□F 90 217-09-5801 Sept. 9,1908 Maryland Usuel Residence of Decedent 10a, Stata 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yas 2 1 No Md. Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 14065 Travilah Rd. 20850 United States 12. Was Decedent Evar In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - American Indian, 11. Marital Status Black, Whita, atc. 1 Never Married 2 → Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Carpenter 12 Construction 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Clarence E. Mills Betsy Reed 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Nora Ella Mills (Wife) 14065 Travilah Rd. Rockville, Md. 20850 20b. Pleca of Disposition (Neme of cematery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Steta 1 Burial 2 Cremation 3 Ramovel from State 3/5/1999 Rockville, Md. 4 ☐ Donetion 5 ☐ Other (Specify) Parklawn Memorial Park 22. Name end Address of Fecility DeVol Funeral Home 21. Signatura of Funaral Service Licensee 10 East Deer Park Dr. Gaithersburg, Md. 20877 23e. Perf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heer failure. List only one ceuse on each line. Approximete intervei Between Onset end Deeth Immediate Ceuse (Finel diseese or condition resulting in deeth) LUNG CANCER Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dfd tobacco usa contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were eutopsy findings availeble prior to 24a. Was en autopsy performed? completion of cause of deeth? 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No 26. Piece of Deeth (Check only one) Other: 4型 Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Examiner The law requires that the death certificate be executed physician and s the burial-transit Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl signed by the a been si should Completed is certificate has director, page 2 at or Attending Physician: T s efter deeth. I Director: After this certificat od in by the funeral director, p Certification: To

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show adical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural; or iten any injury or other traumatic event, the Modical Evantine once.

Physician

/Medical

Examiner

by

Be

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Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

Be

with the Maryland

deeth

25. Wes case referred to medical exeminer?

5 Pending

investigetion

6 Could not be determined

28b. Time of 28e. Date of Injury (Month, Dey Year)

28c. Injury at Work? 1 Yes 2 No 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rurel Route Number, City or Town, State)

12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and dua to the cause(s) and menner as stated 2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certified

27. Menner of Deeth

1 Naturel

2 Accident

3 Sulcide

29a, Certifier

4 Homicide

(Check only one)

29c. Licensa number

29d. Date signed (Month, Day, Year)

D06349

3/2/1999

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

Dr. John E. Kelly M.D. 2401 Research Blvd. #340 Rockville, Md. 20850

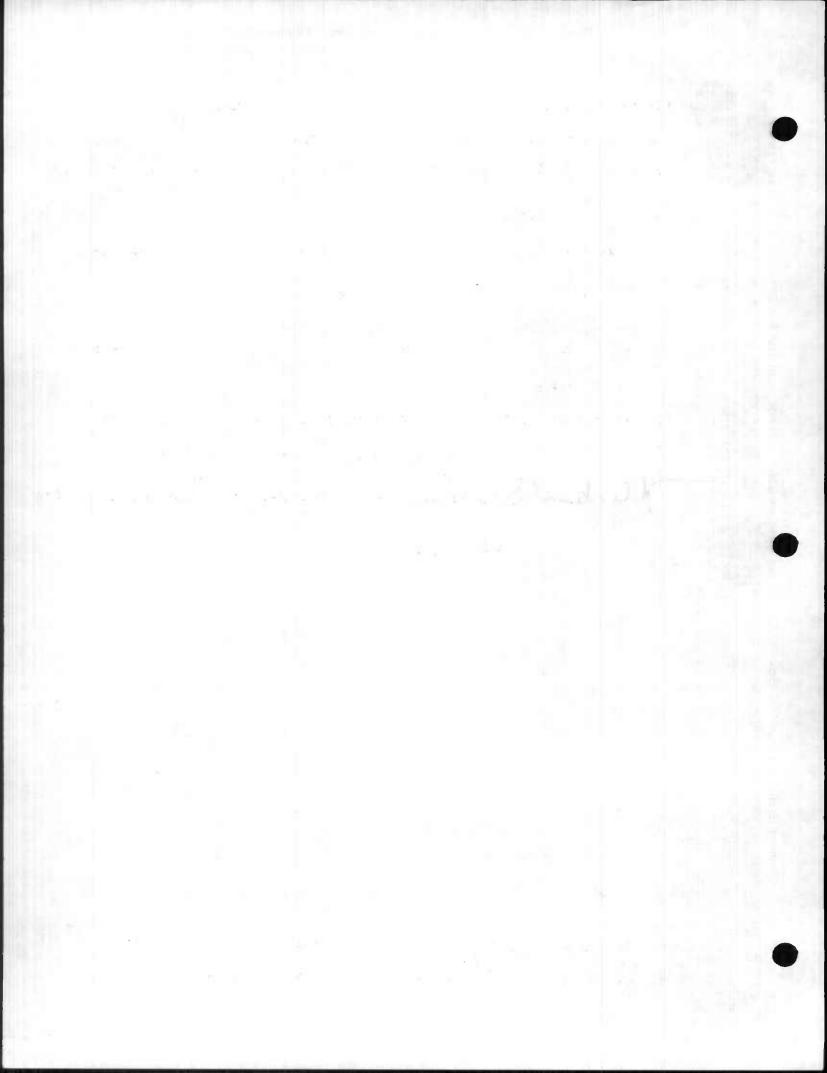
Registrar

31. Dete filed (Month, Day, Yeer) MAR 05 1999 32. Registrer's Signeture

Sparker

• Funeral Dire

To the Hosp within 24 hor To the Fune completely fi



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #8, 3/8/99, BMW, Montg. Co. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month Beulah E. Minton EBRUARY 27,1899 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 24 Hrs. 8. Date of Birth 6-30-1915 irrhplace (State or Foreign Hours | Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🗓 F 83 Director 1915 West Virginia 236-07-6770 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yas 2 No Director 288-1 Montgomery Silver Spring 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? ò 9727 Mt. Pisgah Road Nerra 23s 20903 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 1 Never Married 2 Married b Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White py 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Meiden Surneme) permit. Pages 1 and 2 should be fix.
Department of Health and Wental Hy
Important: If Item 27 is marked oth-any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Fred James Mary James 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ${
m MD},~2090$ ${
m 3}$ (son) David Minton 10120 New Hampshire Avenue, Apt. 205, Silver Spring 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ☑Other (Specify) Entombment Blue Ridge Cemetery 3/3/99 Beckley, WV 22. Name and Address of Facility Francis J. Collins Fu Home, Inc. 500 University Blvd. West Collins Funeral 21. Signature of Funerel Service Licensee al. Silver Spring, MD 20901 atomes 23a. Part it Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Intervat Between Onset and Death **Physician** /Medical Immediata Cause (Final Ventricular fibrillation think minut disease or condition resulting in death) **Examiner** Due to (or as a consequence of): heart disease Examiner valvular Keus The law requires that the death certificate be axecuted Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician at the burial P.O. Box 68760. pneumonia Physician/Medicai Due to (or as a consequence of): fibrillation extrial Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown hypertension of Vital Records. à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No certificate or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1□ Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After 1 Netural Division 5 Pending investigation within 24 hours after death. To the Funeral Director: A 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Sulcide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated Medical 29e. Certifier (Check only one) ag.

State Registrar

31. Date filed (Month, Dey, Year) MAR 0 1 1999

- At mo

29b. Signature and title of certifier

11120

New Houngshire Avenue Svite 305 32. Registrar's Signature

30. Nama and address of person who completed cause of death (tem 23a) (Type, Print) David Plotkin, M.D.

0

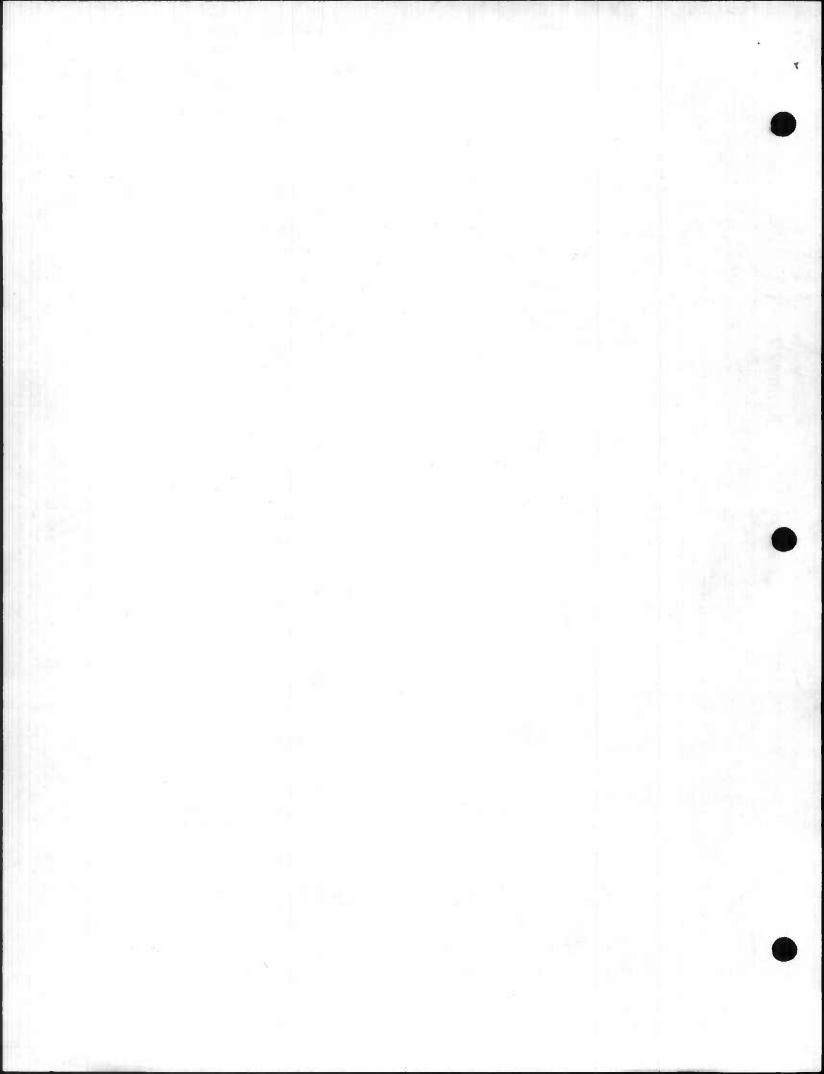
29c. License number

D52481

29d, Date signed (Month, Day, Year)

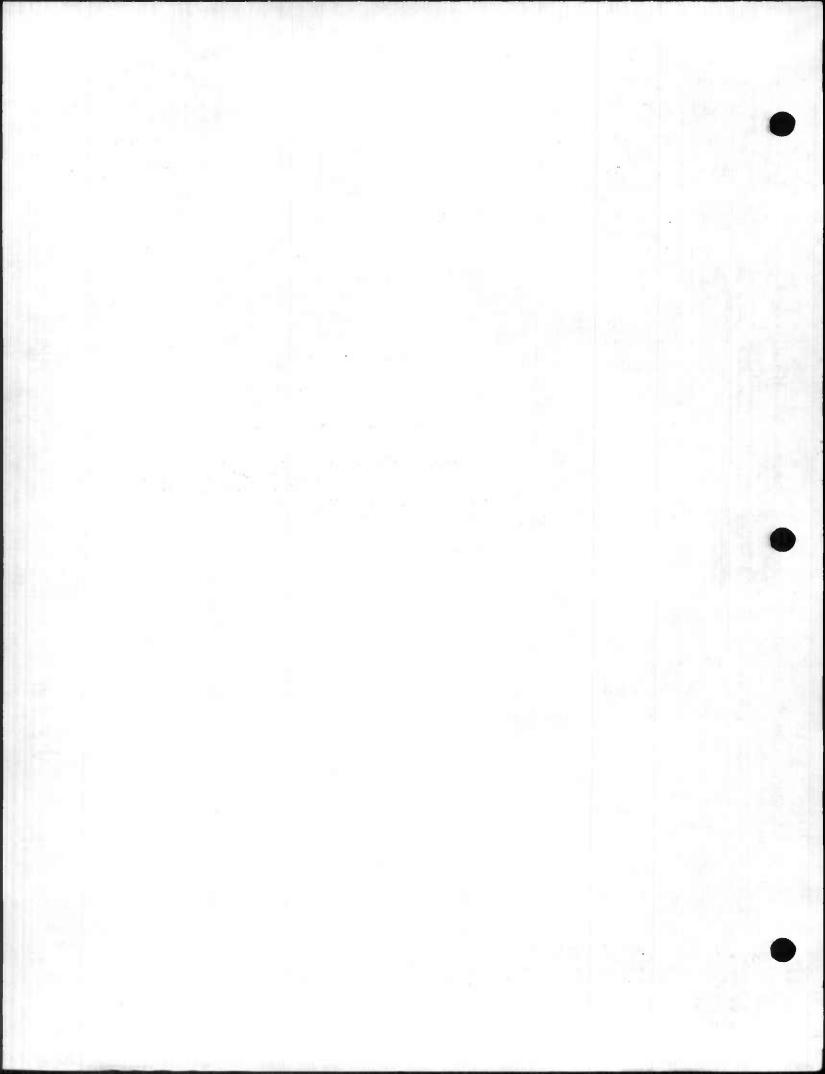
February

Silver Sorin



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1. Decedent's Nama	1. Decedent's Nama (First, Middle, Last)							2. Data of D	Reg. No.		3. Tima of Death	
William Henry Mitchell								Month Februa	Day 1ry 24,19	Year	11:40 PM	
4a Facility Nama (If not institution, give street and number)							lb. City, Town, or				11.40 11.	
5437 MAR	LIN STRE	ET					ROCKVIL	ILLE MONTGOMERY			RY	
5. Social Security Nut 579-12-9	Sex 7. A	A family a				If Undar 24 Hrs Hours Min	8. Data of Bi		9. Birthpl Count	laca (Steta or Foraign try) Land		
Usual Rasidence of D	Decedant 10b. County		100 Ci	h. Tour or l	nation					- 4	24 1-14-02-1-2-	
	MD Montgomery 10c. City, Town or Location Rockville									10	0d. Insida City Limits 1 ☐ Yas 2 ☑ No	
10e. Street and Numb		ery	1	(OCKV1)		Zip Code			10g. Citizen of V	that Court		
5437 Mar		et			101. 2		0853		US US		uy r	
11. Marital Status 1 Never Married 3 Widowed 4	-	Armed Forces	12. Was Decedent Evar in U.S. Armed Forces? 1 Tax as 2 No Il Yas, Giva Yaar or Dates: 1944–46					Specify Yas or N to Rican, atc.)	o- 14. Race Blace Specify	e - Amarica k, Whita, a		
	5. Decedent's Ed						ation		16b. Kind of Bu			
(Specify Elementary/Second	only highast gra	College (1-4or 5+) College Service For					ual Occupation ork done during most of working use retired)			C&P Telephone Compa		
17. Father's Nama (F	irst, Middla, Last,							me (First, Middle	la, Meiden Surnama)			
William l	Henry Mi	tchell					Pear1	A. Denr	nis			
19e. Informant's Nam	ne/Ralationship (Type, Print)		19b. Maili	ng Addre	ss (Street	and Number or R	ural Routa Numi	ber, City or Town,	State, Zip	Code)	
Jean M. N	Mitchell	(w	ife)				treet, R	ockville	e, MD 20	0853		
20a. Mathod of Dispo 1 ☑ Burial 2 ☐ 4 ☐ Donation 5	Cremation 3	Removel from Stete	9		metory o	on (Nama of ory or other place) Data 20c. Location - City or Town, Stata 20c. Location - City or Town						
21. Signature of Fund	aral Service Licer	22. Nama and Addrass of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901								eral		
23a. Part 1-Enter tha disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teilure. List only one cause on each line. Approximation in the mode of dying, such as cardiac or respiratory arrest, interval Bet Onset and												
Immediata Causa (Fi disaasa or condition rasulting in death)	nal	a. EM	EMPHYSE MA 37								3YR.	
Sequentially list condif any, leading to immoduse. Entar Undarly Cause (Disease or In that initiated events rasulting In death) La		Due to (or as a consequence of):										
Sequentially list cond if any, leading to immore causa. Entar Undarly Cause (Disease or In	litions, nediata ving	D	Dua to (or as a consequence of):									
that initiated events rasulting in death) La		Dua to (or as a consequence of): d										
Part II Other significa	ant conditions o	stributing to death but not resulting in the underlying causa given in Part I.						23h Did	I tobacco use cor	tribute to	the cause of death?	
	UlmanA							1 Free 2 No 3 Probably 4				
								24a. War	s an autopsy ormed?	ava	ara autopsy findings ailable prior to appletion of causa death?	
								10	Yas 2 No	1 [Yas 21 No	
25. Was casa ralarre	d to medical						26. Place of De	ath (Check only	one)			
axaminar? 1 ☐ Yas 2 ☐ N	0			ER/Outpatie	nt 3🗆	DOA Oth	er: 4 Nursing I	loma 5 ⊡*Ras	idence 6 Oth	ar (Specify)	
27. Mannar of Death 1 Natural 2 Accidant	5 Pending invastigation		ury ay Year)	28b. Time o Injury	M	28c. Injun Wor	yat k? Yas 2 □ No	28d. Describe how injury occurred				
3 ☐ Suicida 4 ☐ Homicide	6 Could not be detarmined	28a. Place of I	28a. Place of Injury - At homa, larm, street, lactory, office building, atc. (Specify)						(Street and Numb own, Stata)	er or Rura	l Route Number,	
		ysician: To the besiner: On the basis and manner s	of examine									
29b. Signatura and tit	la of certifier	- 7117			2	9c. Licens	e number		29d. Data signed	d (Month, i	Day, Year)	
5.4	1. mg	T, MO				023	630		Frbrusty	, 25,	1999	
30. Neme and addres	s of person who	completed cause of	death (Iter	n 23a) (Type,	Print)	ECK	RD #21	3 6.02	THERIAL	IRL.	MD 20877	
PRANT 6	0. Neme and address of person who completed cause of death (Item 23a) (Type, Print) FRANK J. MAYO, MD 16324 FRENERICK ED #213, 6AITHERIBURS, MD											



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Luella G. Monical February 28 1999 9:40 A.M. /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Montgomery Village Care and Rehab Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Dec. 17 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthpiece (State or Foreign **Funeral** 1 M 2 X F 91 Months: Days Hours Ohio Yrs. 075-26-9313 Director Usual Residence of Decedent the Meryland 10d. Inside City Limits r 28a-f show 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Directo Maryland | Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Heelth and Mentel Hyglene. Important: If item 27 is marked other than "natural", or items 23a or say injury or other traumatic event, the Medical Examples that De in once. United States 10430 Kardwright Court 20886 Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2XX No Specify: Specify: White þ 3 N Widowed 4 Divorcad Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Teacher Education 18 Mother's Name (First Middle Maiden Surneme) 17. Father's Name (First, Middle, Last) Be Bell McCrea Ivan Kintigh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Carol Monical / Daughter 10430 Kardwright Court Gaithersburg, Md. 20886 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 3/1/99 Alexandria, Virginia Metropolitan Crematory 22. Name end Address of Fecility DeVol Funeral Home 21. Signature of Funeral Service Licenses 10 E. Deer Park Dr. Gaithersburg, Md. 20877 Entur the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Immediate Cause (Finel diseese or condition resulting in death) /Medical Acute Myocardial Infarction minutes **Examiner** Due to (or es e consequence of) Examiner Dehydration days physician and s the burial-transit The law requires that the deeth certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest Due to (or es e consequenca of): Box 68760. Physician/Medical Due to (or es e consequence of): ettending p 98 23b. Did tobacco use contributa to the causa of death? ed by the deteched Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. O signed by I 1 Yes 2 No 3 Probably 4 Unknown م Chronic renal insufficiency, Division of Vital Records, þ 24b. Were eutopsy findings avellable prior to been signated 24a. Wes en eutopsy performed? Completed Congestive heart failure, completion of cause of deeth? certificate has b 1 Yee 2 No 1 ☐ Yes 2 ☐ No Dementia is or Attending Physicien: T s effer death. ii Director: After this certificat ed in by the funeral director, p? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how Injury occurred 28e. Date of Injury (Month, Day Year) 28b. Time of 1 Natural 5 Pending 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide • Funeral Di Hospital 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the ceuse(s) and menner es steted. edicai pletely (Check only one) 2 Madical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) To the Vithin 2 end menner stated. 29b. Signature and title of cartifier 29d. Date signed (Month, Day, Year) 29c. License number 041794 Persalla Callatan dyon

Registrar

31. Date filed (Month, Dey, Year)

MAR 0 2 1999

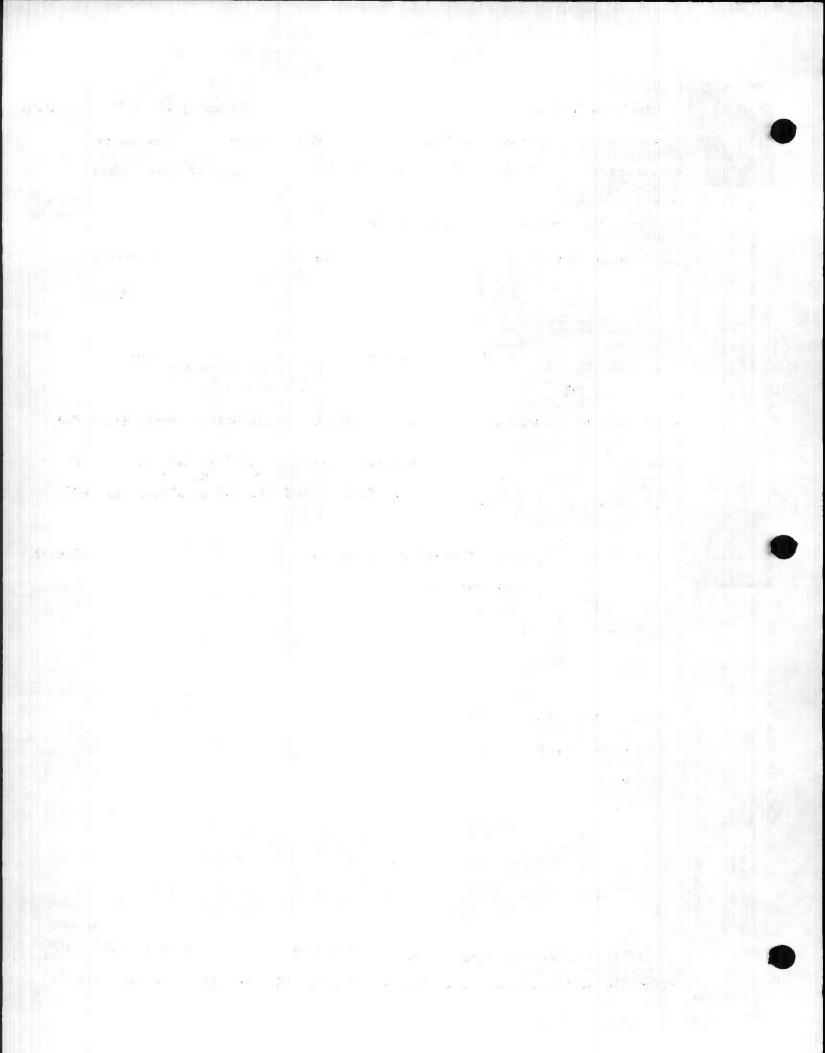
30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signeture

DHMH 16 Rav 6/95

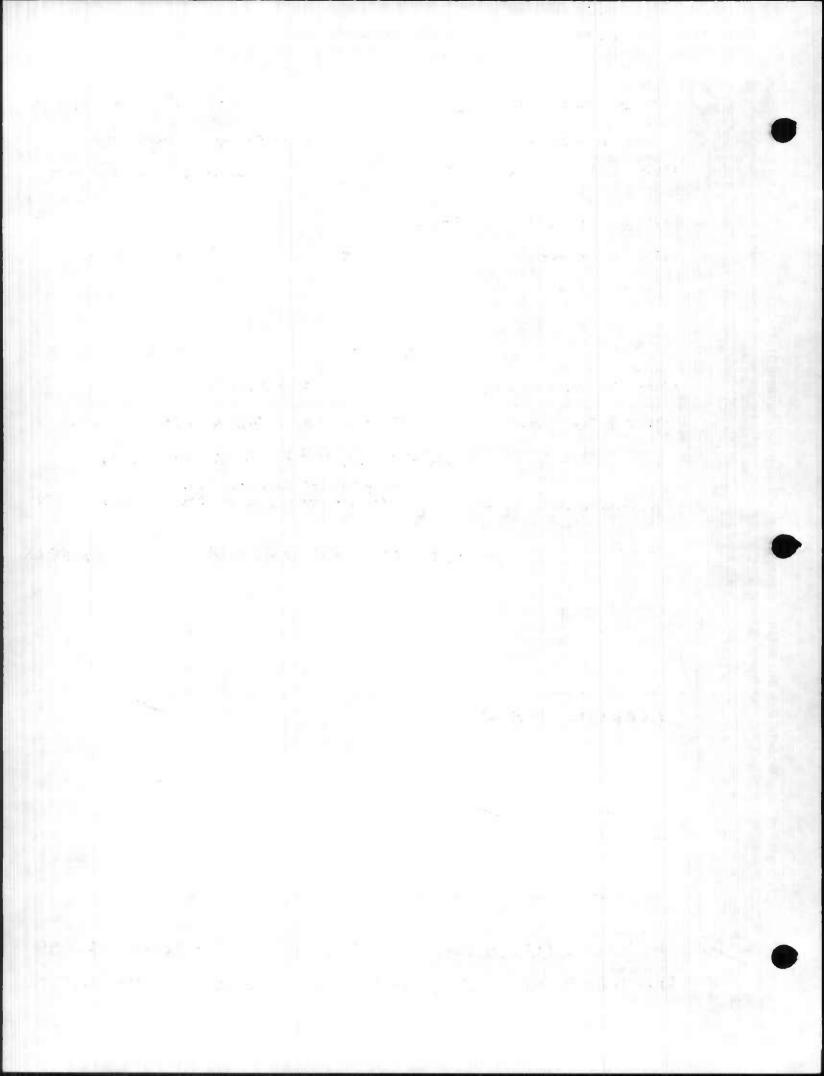
rebrucry 28, 1999

Priscilla Callahan-Lyon, M.D. 911 Russell Ave. Gaithersburg, Maryland 20879



State of Maryland / Department of Health and Mental Hygiene 99 08523

			(Certificate of	Death	F	leg. No.		0060			
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	Holy Cross Hos				Silver		Montgo					
Funeral Director	377 30 2000	7. Aga (In yr		Months Days	If Undar 24 Hr Hours Mir	n. (Month, Day	7 (Year) 5, 1926	Countr	ca (Stata or Foreig y) York			
pue *	Usual Rasidence of Decedent 10a. Stata 10b. County	10c. (City, Town	or Location				10	d. tnslda City Limits			
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th with the 23a or 2 ust be no		enue		10f. Zip Coda 20902			United S					
d within 72 hours efter deeth with the Maryland dylene. glene. The Medical Examiner must be notified at Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedant Evar in Armed Forcas? 1 ☐ Yas 2 ☐ No It Yas, Giva Yaar or Datas:	U,S.	13. Was Decedant of I If Yas, specify Cub 1 ☐ Yas 2 ☐XNo		(Specify Yas or No- irto Rican, atc.)	14. Race Black, Specify:	Whita, at	c.			
ed within 72 hours ygiene. er than "natural", 4, the Modeal Ex-	15. Decedant's Ed (Spacify only highast gra		16a. D	ecedent's Usual Occup	oation during most of w	orkina	16b. Kind of Busi	iness/Indu	stry			
c - 6	Elementery/Secondary (0-12)	College (1-4or 5+)		Giva kind of work dona ita. DO NOT usa ratire	d)	orking .						
filed within Hygiene.		4	S	Sales Clerk			Retail					
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2 should end Men is marke eumatic	19a. Intormant's Name/Ralationship (Type, Print)	19b. l	Mailing Addrass (Street	and Number or F	Rural Routa Numbe	r, City or Town, S	tata, Zip (Code)			
CENL	William McCoy (cousin)		07 Shaker	Blvd., C	hagrin Fa	lls, Ohi	lls, Ohio 44				
permit. Peges 1 en Department of Heal Important: If Item 2 any Injury or other	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specification)	Ramoval from Stata G	Place of E cometery, eorge edica	Disposition (Nama of crematory or other platfown Univel School	rsity	Data 3-2-99	20c. Location - C Washingt	gton, DC				
mit. Sertm Sorts / Inju	21. Signature of Funaral Sarvice Licer			22 Nama and Addra	ss of Facility	D A						
90 E 8 8	Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Man											
THE RESERVE	23a. Part. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart tailure. List only one cause on each line.											
Physician /Medical Examiner	Immediata Causa (Final disaasa or condition resulting in death)	a. ASPPA		N PA	MUBU	ONIA		2	WEEK			
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or Attending Physicien: The law requires the effect death. Shrector: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by							performed? av		a autopsy tindings labla prior to pletion of causa seth?			
The law ate hes pege 2						1 🗆 Y	as 2 Lino	10	Yas 2□ No			
certificate rector, peg	25. Was casa rafarrad to medical				26. Plece of D	eeth (Check only o	only ona)					
Physician: this certific ral director,		Hospital: 1 Impatiant 2	□ ER/Outp	atient 3 DOA Ot	hor:	Homa 5 ☐ Resid		(Specify)				
Attending Physic articles of the function of t		28a. Data of Injury (Month, Day Year)	-	na of 28c. Inju		-	28d. Dascribe how Injury occurred					
tal or Attending P rs efter death. al Director: After led in by the funers Certification:	3 Suicida 6 Could not b 4 Homicida determined	28e. Plece of tnjury - At building, atc. (Spe	home, tam cify)	n, straat, fectory, office		28f. Location (Street and Number or Rural Routa Number, City or Town, Stele)						
To the Hospital or within 24 hours effe To the Funeral Dir completely filled in Medical Cert		ystctan: To the best of my k niner: On the basis of axami and mannar statad.	nowledge, onetion and/	deeth occurred at the ti or invastigation, in my	me, date end place opinion, death oc	ce, end due to the c curred at tha tima, c	euse(s) end men data and place, ar	ner es ste nd dua to	ited. tha causa(s)			
Neithin Me	29b. Signature and titla of certifiar			29c. Lican	sa number		29d. Data signed	(Month, D	lay, Year)			
20) Vhu	Mary	>	D 33	224	F	EBRUAR'	4 2	8, 1999			
State	30. Nema and addrass of person who RAM TREHAN 31. Data filed (Month, Day, Year)	MD SDW 4	ME	S NOTZN C	or F	POCKVILI	E n	40 0	52209			
Registrar	MAR 0 2 19			9. Spar	2							

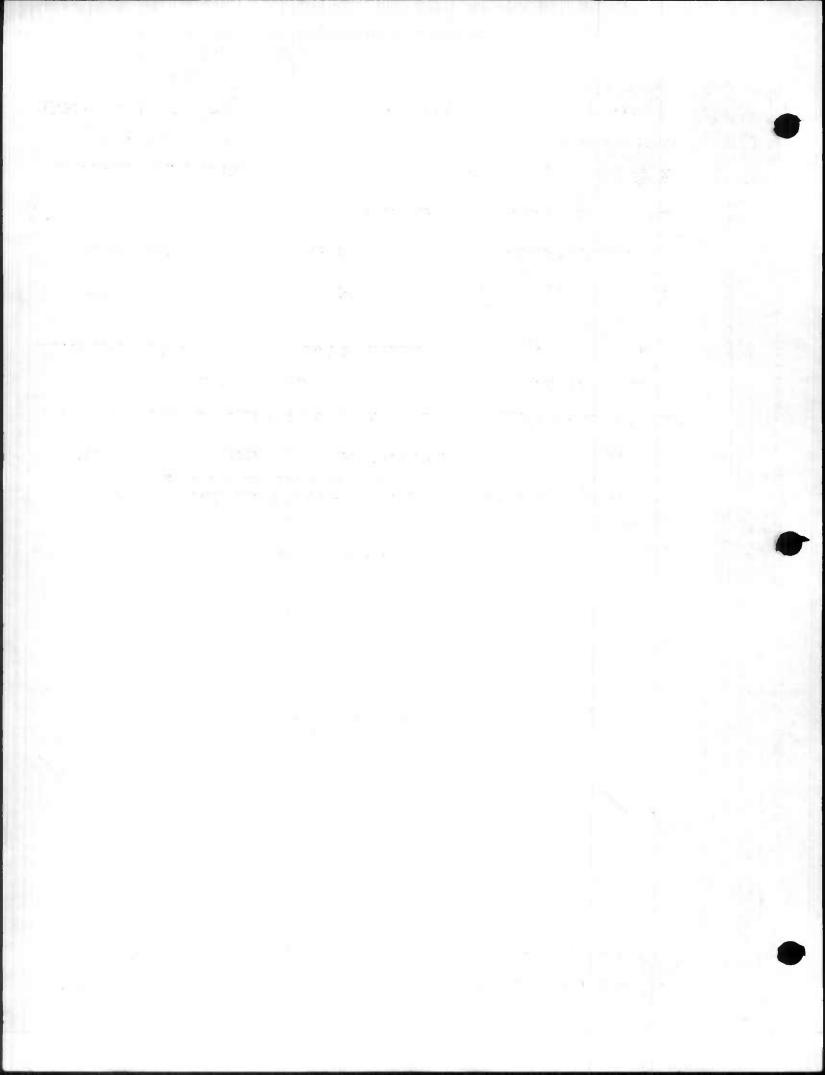


State of Maryland / Department of Health and Mental Hygiene O Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Mulvihill Month **Physician** Edward 1300 02 /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Rockville Montgomery Shady Grove Adventist Hospital Hours Min. 8. Dete of Birth Aug. 12, 1953 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** 1 M 2□ F Months Deys PENNSYLVANIA Yrs. 45 Director 218 66 8026 Usuel Residence of Deceden 10a State 10b. County 10c. City, Town or Location r than "naturel", or items 23s or 28s-f show the Medical Example; main be notified at 10d, Inside City Limits GERMANTOWN MONTGOMERY 1 ☐ Yes 2 No MD. Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20874 UNITED STATES 12229 BRITTANIA CIRCLE Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. filed within 72 hours after 1 Never Merried 2 Married 21215-0020 1□ Yes 22No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16e. Decedent's Usuel Occupetion
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) 12 Peges 1 and 2 should be filed within nent of Health and Mentel Hygiane. nnt: If Itam 27 is marked other than ' ary or other traumatic event, the Mar College (1-4or 5+) SYSTEMS ANALYST BANKING ASSOCIATION Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be **FLORA** DANTON MULVIHILL MARTIN 19b. Malling Address (Street and Number or Aural Route Number, City or Town, Stete, Zip Code) 8728 DELCRIS DRIVE, MONTGOMERY VILLAGE, MD. 20886 19e. Informent's Neme/Reletionship (Type, Print) CYNTHIA M. DICEY, SISTER 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Depertment of important: If any injury or once. 3/1/99 METROPOLITAN CREMATORY ALEXANDRIA, VA. permit. 21. Signeture of Funerel Service License 2MURTER AGRESS BARBER FUNERAL HOME M P.O. BOX 5038, LAYTONSVILLE, MD. 20882 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final diseese or condition resulting in deeth) **Examiner** Due to (or es e consequence of) Examiner The law requires that the deeth certificate be executed Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury thet Initieted events resulting in deeth) Lest pue Due to (or es e consequence of) Box 68760, physician Physician/Medical the Due to (or es e consequence of) signed by the attending d be detached for use es Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by 24b. Were eutopsy findings evelleble prior to completion of ceuse of death? 24e. Wes en eutopsy performed? hes 1 NYes 2 No certificate To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Piece of Deeth (Check only one) ို 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 1 Inpatient 2 □ ER/Outpetlent 3 □ DOA 28a. Dete of Injury (Month, Dey Year) Certification: 27. Menger of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Plece of injury - At home, ferm, street, fectory, offica building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) end menner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 0 30. Neme and edd ess of person who completed cause of deeth (Item 23e) (Type, Print) SHADY GROUG Dennis 1-niBOMAN 31. Dete filed (Month, Dey, Year) MAR 0 2 32. Registrer's Signeture

DHMH 16 Rev 6/95

State Registrar

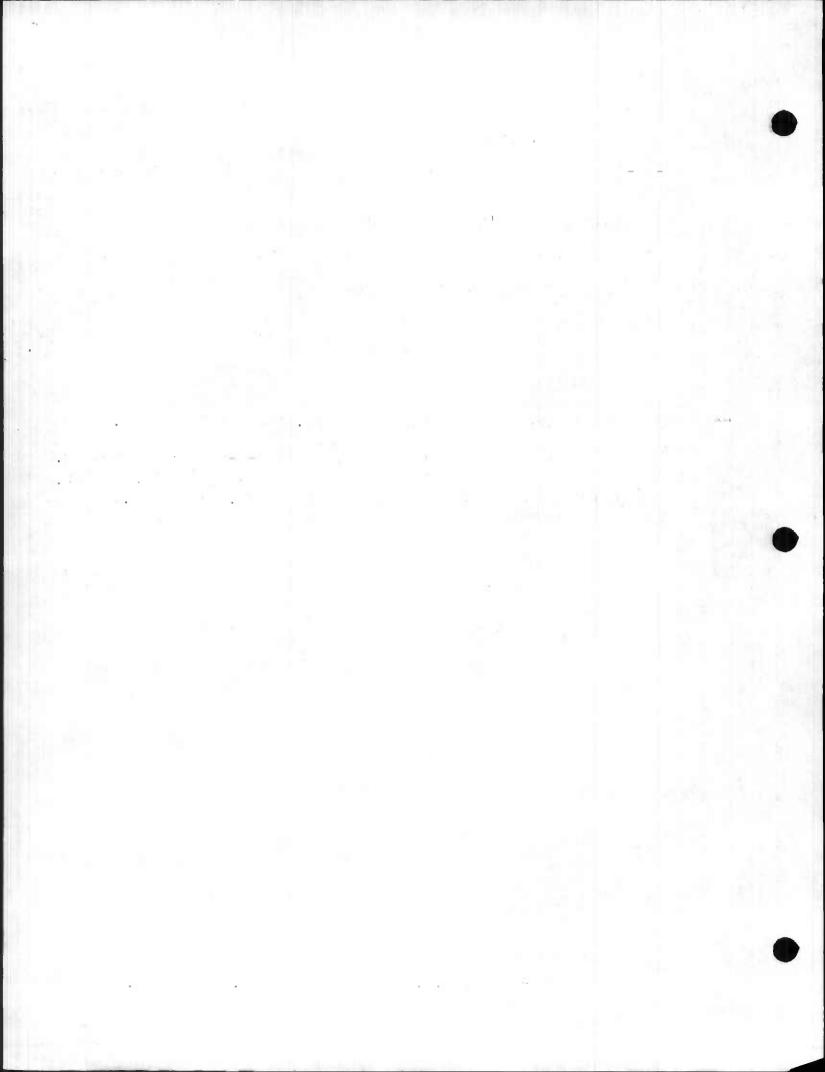


State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** SAMUEL GRANT MUNDY, SR ation of Death | 4c. County of Death 1999 2:15 Am /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PARK WASHINGTON ADVENTIST HOSPITAL TAKOMA MONTGOMERY If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Dete of Birth (Month, Pay, Year) 0 CT 30 1923 6. Sex 12 M 2□ F 9. Birthplaca (Steta or Foreign **Funeral** Days Months Hours ELVERTON, WV 234-34-3015 75 Yrs. Director Usual Residence of Decedent the Maryland 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits "natural", or flams 23a or 28a-f ahow 1 Yes 2 No Director MD PRINCE GEORGE'S SEAT PLEASANT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 6309 GREIG STREET UNITED STATES death Funeral 12. Was Decedent Ever in U,S. Amed Forces? 1 Ď Yes 2 □ No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11 Merital Stetus filed within 72 hours after 1 Never Married 2 Merried 21215-0020 1 Yes 2 No Specify: Specify: þ BLACK 3 ☐ Widowed 4 ☐ Divorced Hygiene. other than "nature ent, the Medical I Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FEDERAL PROTECTIVE OFFICER FEDERAL GOVT. Baltimore, Maryland 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) permit. Pages 1 and 2 should be f Department of Health and Mental F Important: If them 27 is marked of eny Injury or other traumatic even PETER MUNDY ANNIE TYREE 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OPAL MUNDY / WIFE 6309 GREIG ST. SEAT PLEASANT, MD. 20743 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stata Dete 1 X Burial 2 ☐ Cremation 3 ☐ Removel from Stata 3-3-99 CEDAR HILL CEMETERY SUITLAND, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Lice 22. Nama and Address of Fecility CAPITOL MORTUARY, INC. MON. WASH., 1425 MARYLAND AVE., NE DC 20002 indications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, one cause on each line. Approximete 23a. Pgrt1. Enter the disease, of shock, or heart failure. Light Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical · respirating arrest Examiner Due to (or as a consequence of): Examine COPD iclan and burial-transit The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): Box 68760. Physician/Medical cardiomymathy physic the b thet initieted events resulting in death) Last Due to (or as a consequence of) 88 nse P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did lobacco use contribute to the cause of death? 1 Type 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were eutopsy findings evailable prior to completion of causa of death? 24a. Wes an eutopsy performed? Completed page 2 certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.
To the Funerel Director: Al completely filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Routa Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) the th 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) Genthin transpart Freen 027657 02-25-99 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) CYNTHIA CRAWFORD-GREEN, M.D. 2041 GEORGIA AVE., NW WASH., DC 20010 31. Date filed (Month, Day, Year) 32. Registrar'a Signature

State Registrar

MAR 0 2 1999

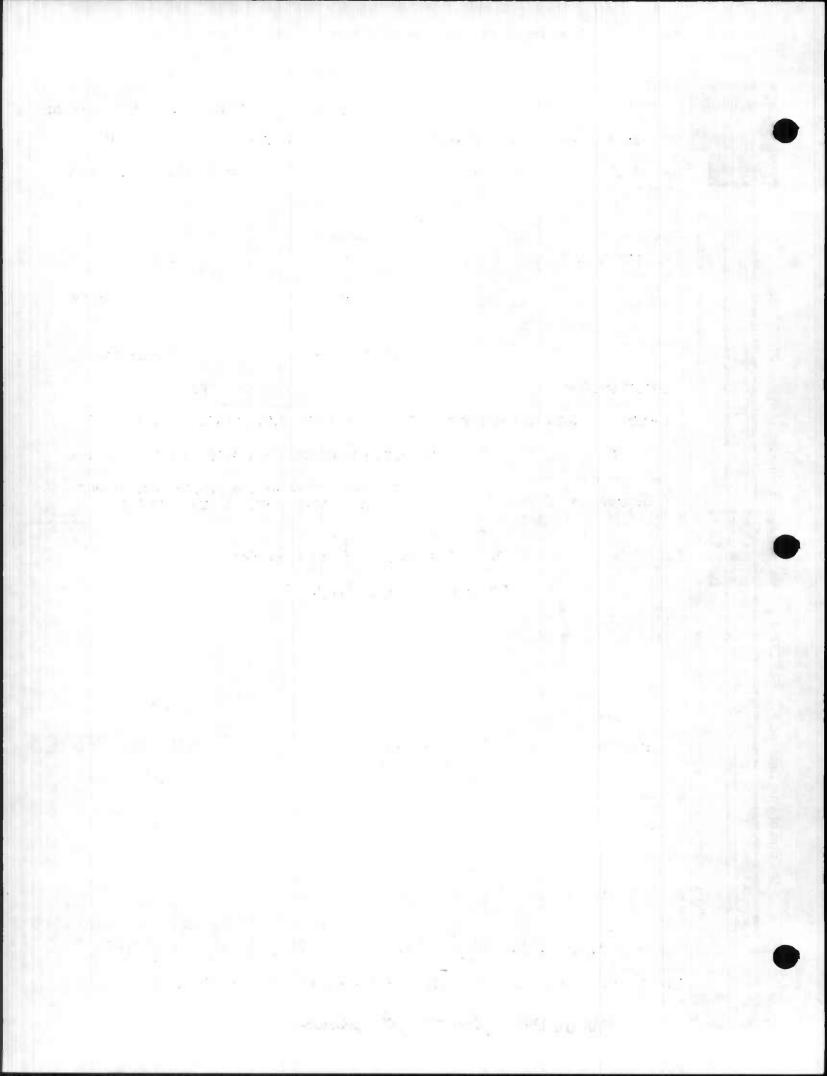


State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth Month **Physician** JOYCE LENORA 2, 1999 MARCH MULINOS 10:55pm /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner WILLIAM HILL HEALTH CARE CENTER TALBOT If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) MAY 2, 1899 5 Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign **Funeral** Months Deys Hours Min 1□M 2€F 99 Yrs. 098-12-4747 MAY MINNESOTA **Director** Usual Residence of Dacedani with the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show N☐ Yes 2☐ No Director MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23s or traumatic avent, the Medical Examiner must be r permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or items 23a and hijury or other traumatic avent, the Medical Examiner mant once. 501 DUTCHMAN'S LANE USA Funeral 21601 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes ZZANo
If Yes, Give
Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes MNo Specify: Specify: WHITE by 3 PWidowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elamantery/Secondery (0-12) College (1-4or 5+) 12 4 REGISTERED NURSE HEALTH CARE 18. Mothar's Neme (First, Middle, Maiden Surnama) 17. Father's Neme (First, Middle, Last) HARVEY STEVENS DONELLA REED 2 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informent's Name/Retetionship (Type, Print) MULINOS/ DAUGHTER MARTNA E. 2500 QUE STREET, N.W., WASHINGTON, DC 20007 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriat 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Othar (Specify) CHESAPEAKE CREMATION CTR 3-3-99 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervet Between Onsel and Deeth **Physician** /Medical Immediate Ceuse (Final / Weel diseese or condition rasulting in death) Examiner Zweeh Examiner certificate be axecuted physician and the burial-transit Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Causa (Disaasa or injury that initieted avants resulting in deeth) Lest Box 68760. Physician/Medical Due to (or es e consequence of) as 980 ò 23b. Did tobacco uss contribute to the causs of death? P.O. ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Pert I. 1 Yss 2 No 3 Probably 4 Unknown signed b Division of Vital Records. P 24b. Were eutopsy findings eveileble prior to completion of ceuse of daath? Completed 24e. Wes en eutopsy paga 2 s 1 Yes 2 No 1 Yes 2 No certificate or Attanding Physician: 25. Was casa referred to medicel exeminer? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 1 Neturel 5 Pending after death. 1 ☐ Yas 2 ☐ No investigation 2 Accident 6 Could not be datermined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Spacify) 4 ☐ Homleide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledga, death occurred at the tima, date end place, end due to tha ceusa(s) and mannar es stated. 29a. Certifier To the Hosp within 24 ho To the Fune completaly fi Medical 2 Medical Examiner: On the basis of axemination and/or invastigation, in my opinion, death occurred et the time, data and place, and due to the cause(s) and menner stated. (Check only one) 29d. Date signed (Month, Dev. Year) 29b. Signeture end title of certifier 29c. License number 30. Neme end eddress of person who completed ceuse of death (Itam 23a) (Type, Print) WILLIAM H. WOOD, JR., M.D., 506 IDLEWILD AVENUE, EASTON, MD 21601 31. Dete filad (Month, Day, Year) 32. Ragistrer's Signeture State

Registrar



Physician /Medical Examiner

Examine

Physician/Medical

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Completed

Be

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Certification:

edical

Maryland 21215-0020

MARSHALL,

physicien end s the buriel-trensit 80 USB ō signed by the e been sig

The lew requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, irector, page 2 s or Attending Physician: director. this funerel After efter death. Director: / To the Hospital or A within 24 hours efter To the Funeral Directompletely filled in by Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

acule Corowary artery

Respiratory

1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an eutopsy performed? completion of cause of death? 1 Yes 2 00 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 DaNo 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Phpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 1 Anatural 5 ☐ Pending 1 Yes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 6 Could not be determined 3 Suicida 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a, Certifier 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of cartifier

29c. License number

29d. Date signed (Month, Day, Year)

23b. Did tobecco use contribute to the cause of death?

MD

D 46020

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

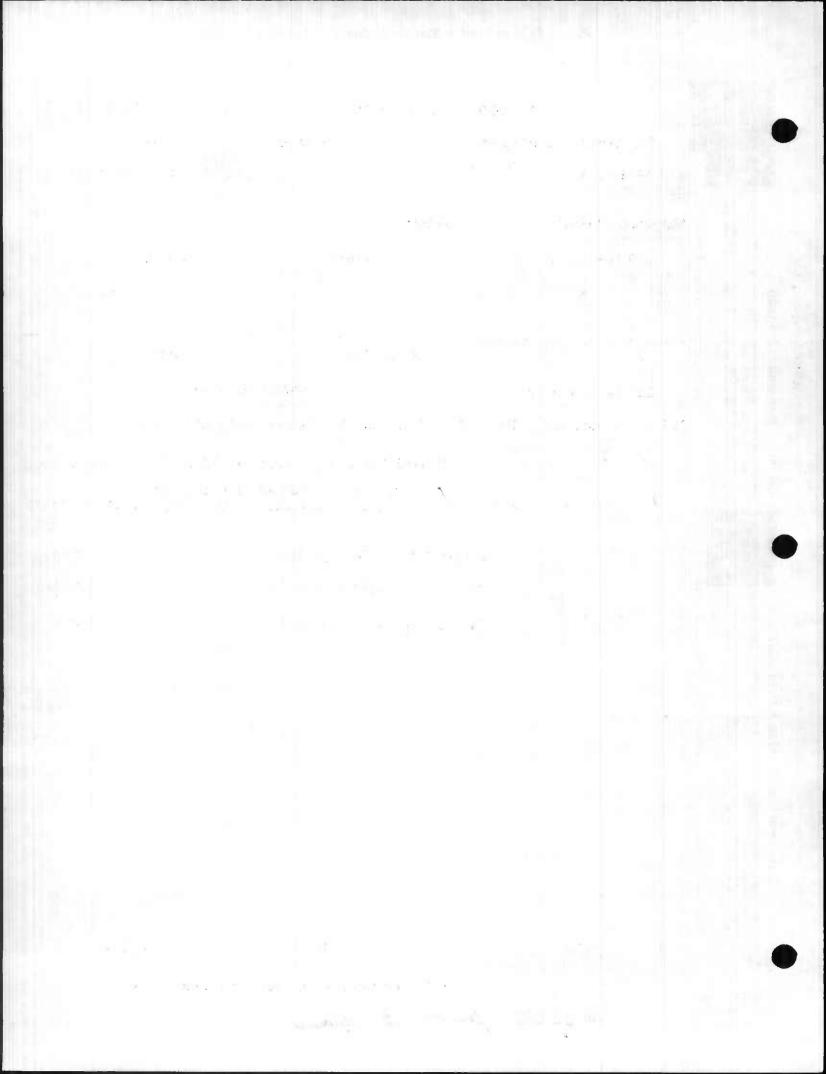
Syed I. Ali 31. Date filed (Month, Day, Year)

506 Idlewild Ave. Easton, Maryland 21601

State Registrar

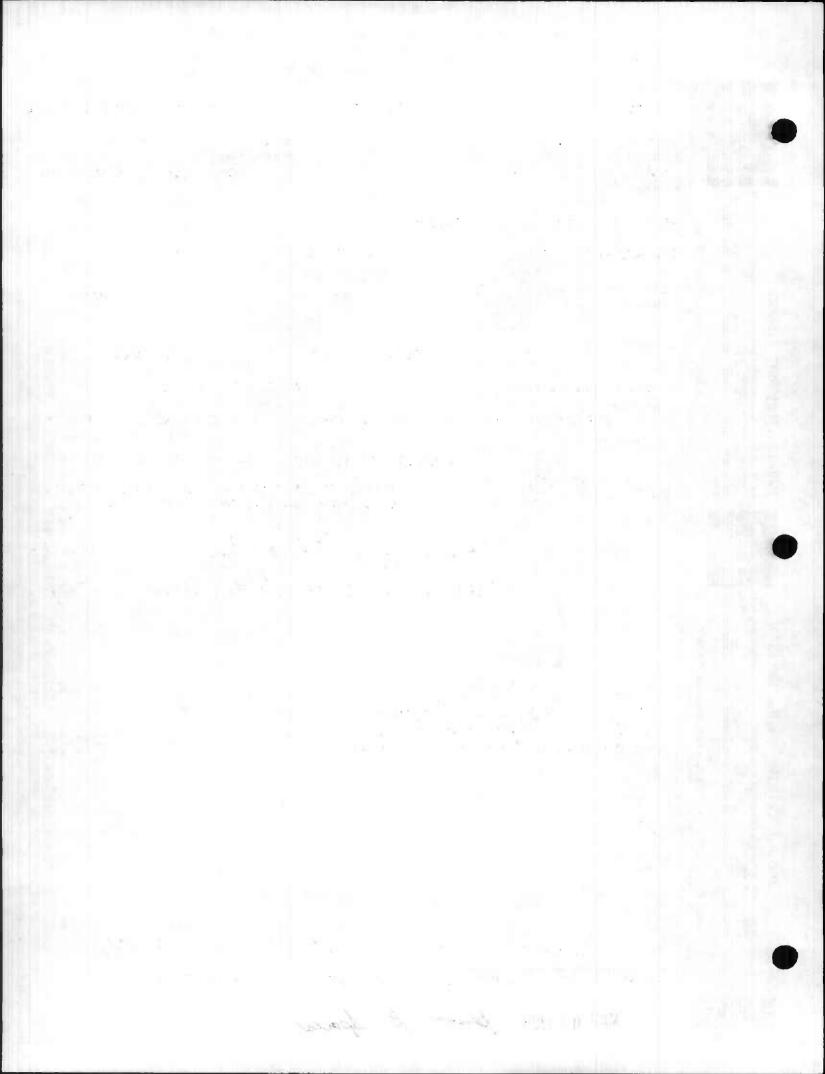
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State of Maryland / Department of Health and Mental Hygiene Q Q 0 5 2 8

					Ce	rtificat	e of	Death			Reg. No.	- 0	0020	
	1. Decedant's Nam	a (First, Middla, La						2. Data of De	eath Day	Year	3. Tima of Death			
Physician /Medical	ELVA	MURPHY								10:45pm				
Examiner	4a Facility Nama (4b. City, Town, or t				cation of Deat	th 4c. Co	unty of Deeth					
		HILL MAN					STON			ALBOT				
Funeral Director	5. Social Sacurity N 200-10-6 Usual Rasidance o	6720	Sax 1□M 2∏ F	7. Aga (In yrs. la 91	ast birthday) Yrs.	If Under Months	Days	if Under Hours	Min.	8. Data of Bi (Month, Di OCT •]	rth a <i>y, Year)</i> 14,1907	9. Birthp Coun PENN	lace (State or Foreightry) SYLVANIA	
nyland	10a. State	10b. County		10c. City	, Town or Lo	cation						1	Od. Inside City Limit	
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after death with the Ma w items 23s or 28s-1s refret roust be notified Funeral Director	10e. Sfreet and Nu 501 DUTO	mber CHMAN'S L	ANE			10f. Zip		601			USA	of What Cour	itry?	
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by		☐ Navar Marriad 2☐ Married CXVidowed 4☐ Divorced		2 No /a /atas:		1 □ Yas				Rican, etc.)		Black, Whita,	HITE	
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marked other umatic avent, I	JOSEPH H. GREEN, SR. KATHERINE MALLETTE													
0 9 6		ame/Ralationship (BROTHER		-				57 REST			Code) TON, MD	
nent of Hee	20a. Method of Dis	•	20b. Placa of Disposition			sition (Nar	tion (Name of story or other place)			Deta	Deta 20c. Location - City or Town, Stata			
in it	9.00	☐ Cramation 3 ☐ 5 ☐ Othar (Spaci			RGETOW	N UNI	VER	SITY	3	3-2-99	WASHIN	SHINGTON, DC		
Department of Health Important: If itam 27 any injury or other to page.	21. Signature of Funaral Saprice Licensee 22. Nama end Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601												OME, P.A.	
Physician	23a. Part1. Entar t shock, or hea		plications that c ona causa on a	caused the daeth ach lina.	. Do not an	ar tha mod	la of dyi	ng, such as	cardiac	or raspiretory	errast,		Approximata Intervel Between Onsat and Death	
/Medical Examiner	Immediate Causa (Final disassa or condition resulting in deeth) e. Coute Ny Cardul Conforcion Dua to (or as a consequence of):									D	6	Milling		
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th. Aftar fune	1 ☑ Neturel 2 ☐ Accident	5 Pending invastigation	(Mon	th, Day Year)	Injury	м	28c. Inju Wo 1 □	rk?]Yas 2□		200. 2000.120		3001100		
on a reaption of attending Physicians: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (3 Suicida 4 Homicide	6 Could not be detarmined	a 28a. Place	of Injury - At horning, atc. (Specify,	ma, tarm, st	reat, tactor	y, offica				(Street and Nown, Stata)	um <i>ber or Rur</i> e	al Routa Number,	
within 24 hours To the Funeral completely filled	29a. Cartifiar (Check only one)	12 Certifying PI 2 Medical Exa	miner: On the bi											
withir To th comp	29b. Signatura and	title of certifiar	burl) 146)	290		sa number	715	anti 0	29d. Data s	gnad (Month,	Day, Year)	
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		H. WOOD,					AVE	NUE,	EAST	ON, MD	21601			
State Registrar		H. WOOD,	JR., M		5 IDLE		AVE	NUE,	EAST	ON, MD	21601			

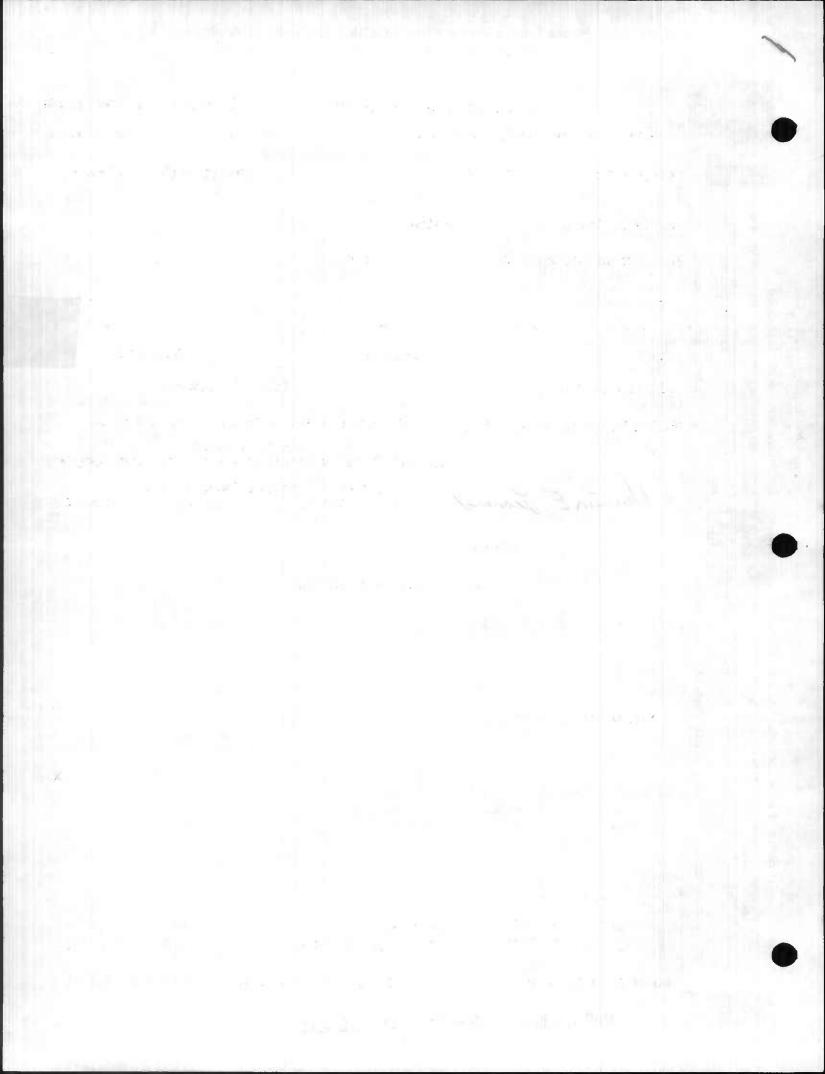


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Neme (First, Middle, Last) 3 Time of Death EBRUARY 24, 1999 **Physician** 11:40 PM ALICE EDWINA McKINNEY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** Saint Joseph Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. Birthplaca (Stata or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days 1□ M 2XF Hours Yrs Director 143-10-9729 May 11,1919 Delaware Usual Residence of Decedent with the Maryland r 28a-f show 10a. State 10c. City, Town or Location 10d. inside City Limits 10b. County 1 Yes 2 □ No Directo Maryland Talbot Easton 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code ? Is marked other than "natural", or items 23s or traumatic event, the Modical Examiner must be a permit. Pages 1 and 2 should be filed within 72 hours effer death we Department of Health and Mentel Hygiene. Important: if Item 27 is merked other than any Injury or other traument. Funeral 201 Federal St. Apt. 29 21601 U.S.A. 12. Was Decedent Evar in U,S. Armed Forces? Was Dacedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 1 ☐ Yes 2 ☐ No If Yes, Giva X Yaar or Dates: 1 ☐ Never Married 2 ☐ Married 1□ Yes 2□ No Specify. by White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Me Kinney, 171 Elementary/Secondary (0-12) College (1-4or 5+) 12 Hostess Restaurant 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Isabelle Mannele William Legg Betts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) P.O. Box 503 St. Michaels, Maryland 21663 Berlin H. McKinney Sr. 20b. Place of Disposition (Nama of cematary, crematory or other place) Eastern Shore 20c. Location - City or Town, State 20a. Method of Disposition 1 Nourial 2 □ Cramation 3 □ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 3-1-99 Hurlock, Maryland 21. Signature of Funeral Service Licansee 22. Name and Address of Facility Harrison E. Leonard Funeral Home 23a. Part1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest,

Approximate

Approximate Approximata Interval Between Onsal and Death **Physician** Immediate Cause (Final disease or condition resulting in death) SEPSIS /Medical Examiner Due to (or as a consequenca of): Examiner URINARY TRACT INFECTION ettending physician and for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated evants rasulting in deeth) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, **Physician/Medical** Due to (or as a consequance of): signed by the e Part II. Other algrificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown ASPIRATION PNEUMONIA þ 24b. Wera autopsy findings available prior to completion of causa of daath? 24a. Was an autopsy performed? Completed is certificate has director, page 2: 2 No 1 Yes 2 No Attending Physician: 25. Was case raferred to medical examiner? Be 26. Placa of Death (Check only one) To Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No this funeral 28a. Date of injury (Month, Day Year) 27. Manner of Death 1 Watural 28b. Time of Injury 28c. Injury at Work? 28d. Dascribe how Injury occurred Certification: After 5 Panding Investigation s efter death. 1 Yas 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicide 28e. Placa of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 2 4 Homicida 24 hours efter • Funeral Dire-letely filled in b ò 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifian To the Hosp within 24 hou To the Fune completely fi edical (Check only one) 29b. Signature and fittle of certifie 29c. License number 29d. Date signed (Month, Day, Year) D37254 30. Name and address of person who completed causa of daath (Item 23a) (Type, Print) BOON P. LIM M.D. 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signatura person G. Sports Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Dev Year Month Anna Elizabeth Morgan February 24 1999 6:30 P.M. 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Mariner Health of Forest Hill Harford Hill Forest 8. Dete of Birth (Month, Dey, Year) 3/18/1902 If Under 1 Year 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) Deys Hours 1 M 2 F Months Yrs. 96 213-74-5785 Maryland Usuel Residence of Decedent 10a. Stete 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yes 2 No Md. Harford Forest Hill 10e. Street and Number 10f. Zip Code 10o. Citizen of What Country? 21050 2260 Phillips Mill Road U.S.A. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. Armed Forces? 14. Race - American Indien, Bleck, White, etc. 11. Meritel Status Yes 2 No f Yes, Give 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 No Specify: Specify: Caucasian 3 Widowed 4 □ Divorced Yeer or Detes: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Robert Smith Livezey Mary Ann Swartz 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 3731 Old Federal Hill Rd. Robert S. Bishop/Nephew Jarrettsville, Md 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) William Watters Cem. 1999 Cooptown, Maryland 22. Name end Address of Fecility E.G. Kurtz & Son Funeral Home, P.A. 21. Signeture of Funerel Service Licenses ver Jarrettsville, Maryland 23a. Part1. Enter the disease, or complications that caused shock, or heart feilure. List only one cause on made lin eth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete Interval Between Onset end Death Immediate Cause (Finel disease or condition resulting in deeth) Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or as a consequence of): Pert It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yes 25. Was case referred to medical examiner? 26. Placa of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ 676

Physician /Medical Examiner

be executed

Box 68760

P.O.

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Division of Vital

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permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy (reportant): if New 27 is marked other any Injury or other transfeed other.

altimore, Maryland 21215-0020

Examiner must be notifi

physician and the burial-transit signed by t

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certificate

edical Physician/M by Completed Be Medical Certification: To 27. Menner of Deeth

To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director,

29e. Certifier (Check only one) 29b. Signature

Naturel 2 Accident

3 Suicide

4 Homicide

Cartilying Physician. To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner as stated cat Examiner on the bests of exprenetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the

investigetion 6 Could not be determined

28e. Dete of injury (Month, Day Year)

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28b. Time of

28c. tnjur at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rurel Route Number, City or Town, State) inetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the ceuse(s)

28d. Describe how injury occurred

30. Name and eddress of person who

NOA

5 Pending

d cause of death (Item 23a) (Type, Print) nelu 0

29d. Date signed (Month, Day, Year)

31. Dete tiled (Month, Day, Year) State Registrar

MAR 03

32. Registrar's Signature

14 2 11 20 14

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3 Time of Deeth James John Martin 25, Feb. 1999 0810 AM 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Harford Memorial Hospital Havre de Grace Harford If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) If Under 1 Year 5. Sociel Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) Days 13 M 2□ F Months Yrs. 214-49-6120 33 Dec. 8, 1965 Maryland Usuel Residence of Decedent 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits 1 Yas 2 No Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1199 Hanson Road 21040 USA Was Decedant Ever in U,S. Armed Forces? Was Dacedant of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Raca - American Indian. 11. Marital Status Biack, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Farmhand Agriculture 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Charles William Martin, Jr. Ethel May Webber 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Stephanie Anne Martin/Wife 1199 Hanson Road, Edgewood, MD 21040 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriel 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) St. Paul's Cemetery 3/2/99 Aberdeen, MD 22. Name end Address of Facility 21 Storuture of Funeral Servica Licensee Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 and Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Appropriately an analysis of head universe List only one cause on each line. Approximete Intervai Batween Onset and Death Immediate Cause (Finel diseesa or condition resulting in death) IDAY HEART FAILURE CONFESTIVE Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy parformed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Neturel 5 Pending investigation 1 Tyes 2 No

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aftar deat Director: 24 hours To the I

Martin, Vames

Registrar

31. Date filed (Month, Day, Year)

29b. Signeture end title of certifier

2 Accident

3 Suicide

29a. Certifier

Medicai

4 | Homicide

(Check only one)

MAR 0 2 1999

6 Could not be determined

MI DREW NOWAKONSKI 32. Registrar's Signeture

Andres Nowalent mo

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

28e. Pieca of injury - At home, ferm, street, fectory, offica building, etc. (Specify)

mo

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner stated. 29c. Licensa number

29d. Date signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

FOBRNARY 25, 1999

125 N. MAIN ST BEL ATRMD 24014

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 99 Isabel Baker Moore MARCH 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Fallston General Hospital **Fallston** Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 M 200 210-15-7228 82 6/9/16 Maryland Usual Residence of Decedent 10e. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MOWes 2 No MD Harford Bel Air 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2101 Fairlane Road 21015 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 Yes 2 140 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 1 to Specify: Specify. 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Assistant Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Charles Harvey Baker Mary Ann Coale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Nathan W. Moore 3rd- son 26 W. Belcrest Rd., Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Locetlon - City or Town, Stete txxurlai 2 ☐ Cremation 3 ☐ Removal from Stete Harford Mem. Gardens 3/5/99 Aldino, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harkins F.H. Inc., 600 Main St., Delta, PA 17314 23a. P. 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveileble prior to completion of cause of death? 24e. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) I patient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No

Physician /Medical Examiner the death certificate be executed

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To this Certification: after deeti Director: 3

Division of Vital Records, P.O. Box 68760,

or Attending Physician:

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24 hours

within 2

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Was case examiner?

1 Yes 2 N 27. Menner of Death Maturel 2 Accident

6 Could not be determined 3 Suicide 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as steted. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) end menner stated. 29d. Date signed (Month, Dey, Year)

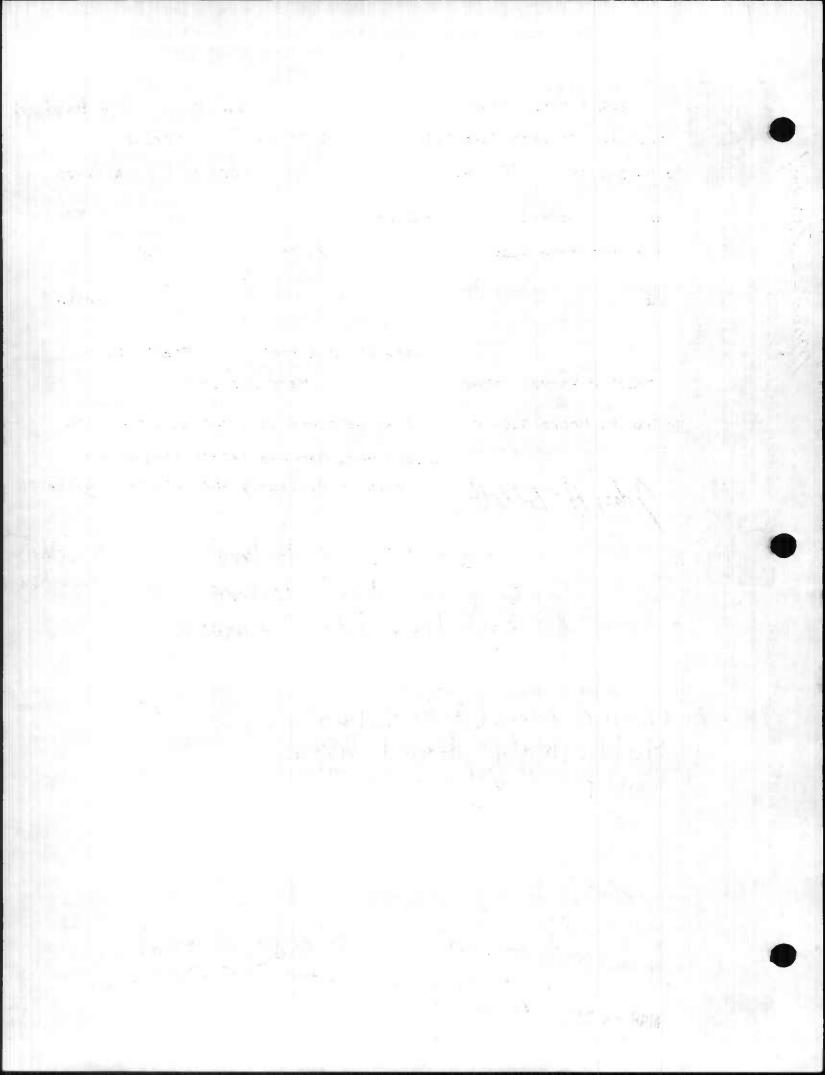
29b. Signature and titla of certified

Registrar

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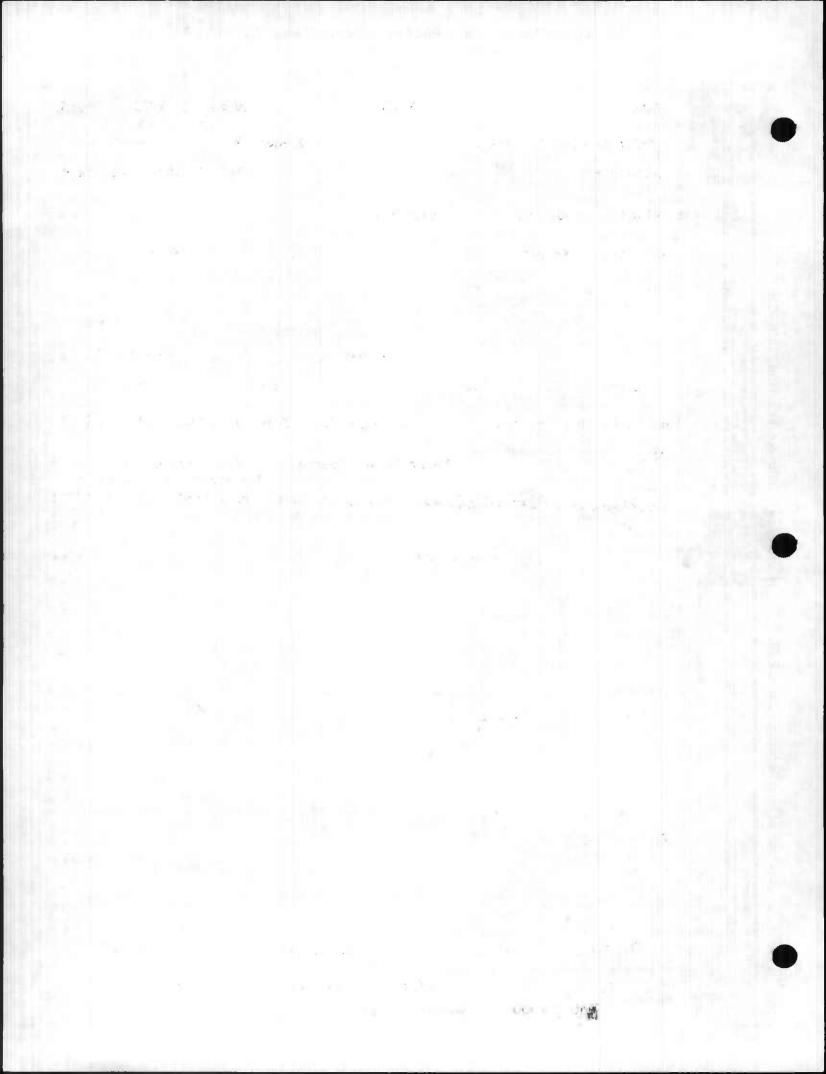
30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature

MAR - 4 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Decedent's Neme (First, Middle,	Last)	-5/10	50/11	ificate of		2. Dete of Dea Month MARCH			ne of Deeth		
ysician Iedical	JEAN	L.	MINCH					5, 1999	Year 10:	37		
aminer	4a Facility Name (If not institution,		r)			4b. City, Town, or	Location of Deeth	4c. County	of Deeth			
	Frederick Memo	rial Hospi	tal			Freder	ick	Fred	lerick			
eral ctor	5. Social Security Number 220–28–7986	. Sex 7. /	Age (In yrs.)		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		, 1929	9. Birthplace (Si Country) Marylan	D. Birthplace (State or Foreig Country) Maryland		
	Usual Residence of Decedent 10e. State 10b. County		10c. City	y, Town or Loca	ation				10d. Insi	de City Limits		
once. To Be Completed by Funeral Director	Maryland Fred	erick	F	rederic	k				1 🖾	Yes 2□No		
I Dire	10e. Street and Number 421 Logan St	reet		10f. Zip Code	21701	1	Og. Citizen of V	Whet Country?				
by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Deceder Armed Forces	No		as Decedent of I res, specify Cub	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		a - American India k, White, etc.	in,		
eted t	15. Decedent's (Specify only highest)	Education	cation 16a. Decadent's Usual 0				orking	16b. Kind of Bu	usiness/Industry			
Completed	Elementary/Secondery (0-12)	College (1-4o	College (1-4or 5+)					own home				
Bec	17. Fether's Name (First, Middle, La	st)				18. Mother's Na	me (First, Middle,					
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	19a. Informant's Neme/Relationship						dural Route Numbe					
	Paul L. Minch /	nuspand	20b. P		tion (Name of atory or other pla		erick, MI		City or Town, Sta	te		
	1 Burial 2 □ Cremation 3 4 □ Donetion 5 □ Other (Spe		.0									
	21. Signeture of Funeral Service Lic		Mo		vet Cem			rederick , Maryland				
	Stadilei Funetai non											
	23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
n	shock or been failure. List only one cause on each line. Interval Betwee Onset and Dea											
al er	Immediate Ceuse (Finel disease or condition resulting in deeth) e											
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Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): Due to (or es e consequence of):											
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ysic	Part II. Other algnificant conditions	contributing to death	ontributing to death but not resulting In the underlying cause given in Part I.					23b. Did tobacco use contribute to the ce				
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Con							1 D Y	es 2 No	1 ☐ Yes	2□ No		
Be	25. Wes case referred to medical exeminer?	Hospital: >					eath (Check only o	ne)				
- To	1 ☐ Yes ≱⊠ No 27: Menner of Death	Hospital:		ER/Outpatient	3LI DOA		Home 5 ☐ Resid	Residence 6 Other (Specify)				
ation	1 Naturel 5 ☐ Pending investigat		Day Year)	28b. Time of Injury	M 1	rk? Yes 2 No	200. Describe fi	ow injury occur				
edical Certification:	3 Suicide 6 Could no determine		28f. Location (S City or Tow	itreet and Numb n, State)	per or Rural Route	Number,						
cal	29a. Certifier (Check only one) Certifying 2 Medicat Ex	Physician: To the bes aminer: On the basis and manner	of examinal	wledge, death of tion end/or inve	occurred et the to stigation, in my	ime, date end plec opinion, death occ	e, end due to the curred et the time, c	ceuse(s) and ma date end placa,	anner as stated. end due to the ce	use(s)		
9	29b. Signature end title of certifier				29c. Licen	se number		29d. Dete signe	d (Month, Day, Ye	ear)		
Med								3-5-99				
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completaly filled in by the funeral director, page 2 Medical Certification: To Be Comp	30. Name and address of person what 1475 Taney	2			rint)		mD 2		/ 1			



State of Maryland / Department of Health and Mental Hygiene

							Cer	tificate of	Death		Reg. No.	J. U.O.	334	
	D 1		1. Decedent's Nem	e (First, Middle, Lo	est)					2. Dete of De	ath		Time of Death	
	Physic /Medi		_Henry Ha	errison M	foulder					March	1. 1999	Yeer 4	:18 PM	
	Examir		4a. Fecility Name (lf not institution, giv	ve street and number)				4b. City, Town, or I		h 4c. Coun	ty of Deeth		
					lventist	Hosp	oital		Rockvi			ntgome	_	
L	Funeral Director		5. Social Sacurity N 304-20-5 Usuel Residence of	5622	Sex 7. Ag 1□MM 2□ F	ge (In yrs. 75	lest birthday) Yrs.	Months Deys		8. Date of Bi (Month, Da Dec.]	9, 1923	9. Birthplaca (Country) Kentuc	(State or Foreign	
	yland		10a. Stete	10b. County		10c. City	y, Town or Loc	ation				10d. In	nside City Limits	
	Maria Maria	tor	Maryland	Frederi	ck	Fre	derick					1]	X Yes 2 □ No	
	or 28	Director	10e. Street end Nu	mber				10f. Zip Code			10g. Citizen of	Whet Country?		
	th wi		201 Wyne	gate Driv	7 e			21701			USA			
	eep ,	Funeral	11. Marital Status	3	12. Was Dacedent Armed Forcas?			/as Decedent of I	Hispenic Origin? (Spoan, Mexican, Puarto	pecify Yes or No		ce - American Indack, White, etc.	dian,	
20	72 hours after death with the Maryland natural; or items 23s or 28s-f show dost Examiner, must be notified at	by Fu	1 ☐ Never Marri 3 ☐ Widowed	ied 2 Married	1-∑ Yas 2 ☐ If Yes, Give T Yaar or Dates	No W	WII	□ Yas 21 No		, , , , , , , , ,	Speci	ifv:		
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212	d within giene. rr then "	E O	Elemantery/Seco	ndary (0-12)	College (1-4or	5+)	Army				United	d States	Militar	
nd	be filed withintal Hygiene.	Be	17. Fether's Name	(First, Middle, Last	1)				18. Mother's Nem	e (First, Middle				
yla	should be and Mental s marked or umatic eve	To	Jacob E.	. Moulder					Lily B.	Lawrence	ce			
Mar	2 sho end ls me		19e. Informent's Na	The second secon					t and Number or Ru		-		a)	
	ss 1 and 2 should of Health and Mar Item 27 Is marks other traumatic			oulder, v	vife	1			Drive, Fre			1701		
Baltimore,	Peges 1 nent of H ant: If Ite ury or ot				Removal from State		amatani aram	ition (Name of etory or other pla n Memori	Lal Gar.	3/6/99		- City or Town, S ick, Mar		
Balt	permit. Peges Depertment of Important: If I any Injury or once.		21. Signatura of	nerel Service Lice	nsee P			Name end Addr	Kee				eral Hom	
	4 1		23e. Pert1. Enter fi	he disaase, or con	nplications that caused one ceuse on each li	the deeth			Church Sta			Appr	21701 roximate	
	Physician /Medical		Immediate Ceuse (Finel) F	^				Onse	vel Between et end Death	
	Examiner	l.	resulting in deeth)		A	Due to (or	r es a consequ	ience of):	1	1	/		110110	
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	end end el-tran	xan	Sequentially list con	nditions, imediate		Due to (or	es e consequ	ence of):				1		
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68760,	ficete p phys	Medical	resulting in death) I	_est		Due to (or	as e consequ	ence of):						
×	nding use s	2			d									
Bo	the death by the etter ached for u	cla	Pert II. Other aignif	cant conditions	contributing to death b	ut not resu	liting in the un-	derlylng cause gi	ven in Part i	23h Did	tobacco uso c	ontribute to the	cause of death?	
0.	thet the death cert ed by the ettendin detached for use	Physician/			ominating to doding	30 1100 1000	itting in the time	donying oddso gr	VOIT HET CITES.		Yes 2 No		4 Unknown	
	es the	by F												
Records,	v requires thet been signed b should be deta	be									an autopsy ormad?	24b. Were eu eveileble	topsy findings	
ec C	aw 2 s	Completed										completi of deeth	ion of cause	
	The law ste has b page 2 s	S S								10	Yes 200 No	1 ☐ Yes	2 No	
Vital	ystcian: The I is certificete ha director, page	Be (25. Wes case refer	red to medical					26. Place of Dee	th (Check only	ona)			
of <	Physician: this certific rel director,	2	1 Yes 2□	No	Hospital: 1 ☐ Inpatie	ent 2	ER/Outpetient	3□ DOA Ot	her: 4 Nursing H	ome 5 🗆 Resi	dence 6 □Ot	her (Specify)		
ū	After the funere	on:	27. Menner of Death	h 5 ☐ Pending	28e. Dete of Inju (Month, De	y Year)	28b. Time of Injury	28c. Inju Wo	ry et ork?	28d. Describe	how injury occu	rred		
S	Attending or death.	cat	2 ☐ Accident 3 ☐ Sulcide	investigatio 6 ☐ Could not b	ne				Yes 2 □ No	00/ 1/		0.40	- 111	
Division	al or Attences efter death	Certification:	4 ☐ Homicide determined determined determined determined building, etc. (Specify)							28f. Location (Street end Number or Rurel Route Number, City or Town, State)				
	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After thi completely filled in by the funeral	edical (29a. Certifier (Check only one)	1□ CertifyIng Ph 2 Medical Exar	nyelcien: To the best miner: On the basis of end manner sta	exeminet	vledge, deeth ion end/or Inve	occurred et the ti estigation, in my	me, dete end place, opinion, death occur	end due to the red et the time,	cause(s) end m dete end place	nenner es steted. , and due to the c	euse(s)	
	Mithin Fo the Somp	Me	29b. Signatura and	titla of certifier.		1	<u> </u>	29c. Licans				ed (Month, Dey, 1		
4			Hatu	cia L.	10msks	2 M	12	D	51916		Marc	h /1 19	999	
			30. Name end eddre	ass of person who	completed cause of d	leeth (Item	23a) (Type, P	rint) /	51916 le Pike	-11-	10 1	11	- /	
			Patricia	L. Ton	15KO, MI	2, 11	140 R	ock VII	le Pike	,#348	Rock	ville. N.	10 20850	
	Sta	te	31. Dete filed (Mont	h, Day Year)	32. Registr	ar's Signet	ture	4	1	,				

- (A)

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) Month **Physician** NARON 281 Februar 1999 JACQUELINE 21:12 /Medical 4b. City, Town, or Location of Daath 4a Facility Nama (If not Institution, giva straat and number) 4c. County of Death Examiner H Under 1 Year H Under 24 Hrs. 8- Data of Hirth Months Days Hours Min. (Month, Day, Year) 12.15.1951 Hopkins 6. Sax THE JUHNS HOSPITAL 7. Aga (In yrs. last birthday) 9. Birthplace (Stata or Foraign **Funeral** 1 M 2 By 217.54.7793 47 Yrs. MARYLAND Director Usual Rasidanca of Decedant with the Meryland 10a, Stata 10b. County 10c. City, Town or Location 10d. insida City Limits rithan "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2 ☐ No ARYLAND
10e. Street and MONTGOMERY POTOMAC 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 9909 SORREL AVENUE USA 20854 daeth v Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian. 11. Marital Status e filed within 72 hours aftar d al Hygiene. other than "natural", or frem Black, White, atc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 ☐ Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 WHITE 1 ☐ Yas 2 ☐ No Specify: by 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Spacify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) 5) ART permit. Pages 1 and 2 should be filed v Department of Haalth and Mental Hygien Important: If item 27 is marked other th any injury or other traumatic event, that once. ART CONSULTANT 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) RICHARD NAST LENORA HEILIG 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) STEVEN NARON/HUSBAND 9909 SORREL AVENUE, POTOMAC, MARYLAND 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata JUDEAN MEMORIAL GARDENS 3.3.99 OLNEY, MARYLAND 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licansas 22 Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batwaan Onsat and Death **Physician** Immadiata Causa (Final disaasa or condition rasulting in daath) /Medical HEPATIC VENO-OCCLUSIVE DISEASE THREE WEEKS Examiner Dua to (or as a consaquanca of): Examiner ALLOGENCIC BONE MARROW TRANSPLANT SIX WEEKS attending physician and for usa as tha burial-transit tha daath certificata be executed Saquentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disaasa or Injury Dua to (or as a consaquanca of): P.O. Box 68760, CELL LYMPHOMA CIGHT MONTHS Physician/Medical that initiated avants Dua to (or as a consaguanca of) rasulting in daath) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, ò 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has page 2 No 1 ☐ Yas 2 No cartificate Hospital or Attending Physician: 25. Was casa rafarrad to medical axaminar? funaral diractor, Be 26. Piaca of Death (Check only ona) Hospital: 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No 2 Aftar this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding invastigation Natural eftar daath. Director: Aft 1 ☐ Yas 2 ☐ No 2 Accidant tha 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 3 Sulcida 6 Could not be datarminad 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) 4 ☐ Homicida 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mannar stated. 29a, Cartifian To the Hosp within 24 hou To the Funer complately fil edical 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licansa number February 28, 1999 mal (NO RES-000 20

State Registrar 31. Data filad (Month, Day, Year)

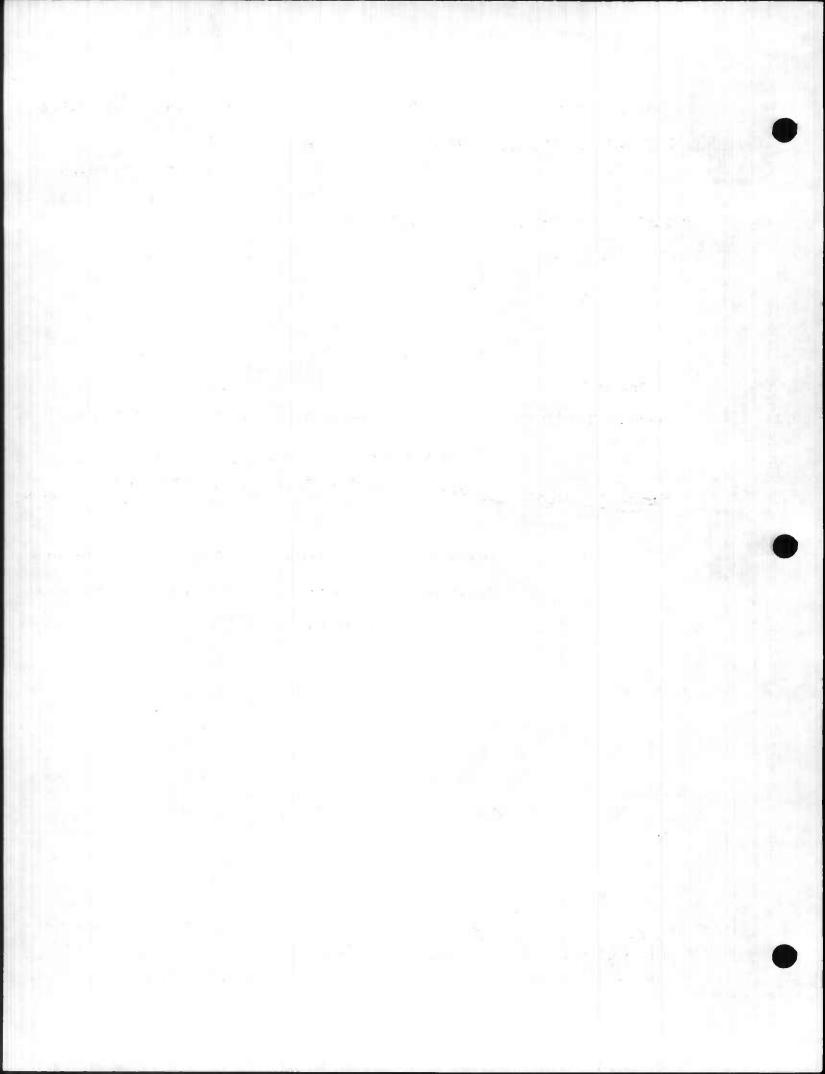
MAR 0 2 1999

30. Nama and addrass of parson who complated causa of death (Itam 23a) (Type, Print)

32. Ragietrar's Signatura

G. Sparks

DAVID G. KAPLAN, NO; GOON WELFE ST., TOWER 110, BALTIMORE, MD 21209



State of Maryland / Department of Health and Mental Hygiene (1) Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Courth **Physician** FEBRUARY 23. 1999 3:21 IM ROSE NORWOOD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth MONTGOMERY **Examiner** BETHESDA SUBURBAN HOSPITAL Months Days Hours Min. B. Date of Birth AUCUS Pay 25a, 1898 Country) ILLINOIS 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) **Funeral** 1 M XXF 100 Yrs. 579-05-5567 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 XXIo Director MONTGOMERY ROCKVILLE MD 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? UNITED STATES 20852 6121 MONTROSE ROAD death Funeral 12. Was Decedent Evar in U.S. Armed Forces? 1 ☐ Yas 2 DNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours efter 1 Never Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 🏋 No Specify: Specify: WHITE δ XX Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest g rade completed) permit. Pages 1 and 2 should be filled within Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "any injury or other traumatic event, Tim Nea. College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME HOME MAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be UNAVAILABLE UNAVAILABLE 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2025 M STREET WASHINGTON DC 20036 LEONARD BURKA (LEGAL REP) 20a. Method of Disposition 20b. Placa of Disposition (Name of cematery, cramatory or other place) 20c. Location - City or Town, Stata 1 XX urial 2 Cremation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON NATIONAL CEMETERY 3/1/99 ARLINGTON VA 21. Signature of Funaral Service Lightsee 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPEL 1170 ROCKVILLE PIKE ROCKVILLE MD 20852 Um 23a. Part1. Enter the disaase, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical tmmediate Cause (Final · Pulmonary Embolus nours disease or condition resulting in death) Examiner t Tibia-Fibula Fracture of Due to (or as a consequenca of): Y. Tomsket, M.D. Examiner weeks attending physician end for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of Box 68760, Physician/Medical Part II. Other algnificant conditions contributing to death but not resulting in the undarlying causa given in Part I. P.O. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus Records, þ 24b. Were autopsy findings available prior to completion of causa of deeth? 24a. Was an autopsy performed? Completed peen has 1 Yes 2 No 1 ☐ Yes 2 No certificate Division of Vital or Attending Physician: effer death. Director: After this certific Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: from wheelchair 5 Pending Investigation Injury 3:00 PM Transfer 1 Natural (Month, Dey Year)

7

100 PM

1 Yes 2 PNo

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify) Hebrew Home of 1 ☐ Yes 2 ZNo 2 Accident to bed 6 Could not be determined 3 Suicida 281. Location (Street and Number or Rural Route Number, City or Town, State) 6121 Montrese Rd 4 ☐ Homicide Rockville, MD 20852 To the Hospital or within 24 hours eft To the Funeral Di completely filled in Greater Washington 29a. Certifier (Check only one) 1 Certifying Physictan: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred et the time, date end placa, and due to the cause(s) and manner stated. 29b. Signature and title of cartifier 29d. Date signed (Month, Day, Year) atharine K. Lillie MA D53244 February 23, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11140 Rockville Pike #348 Katharine R. Lillie, M.D. Rockville, MD 20852

Registrar

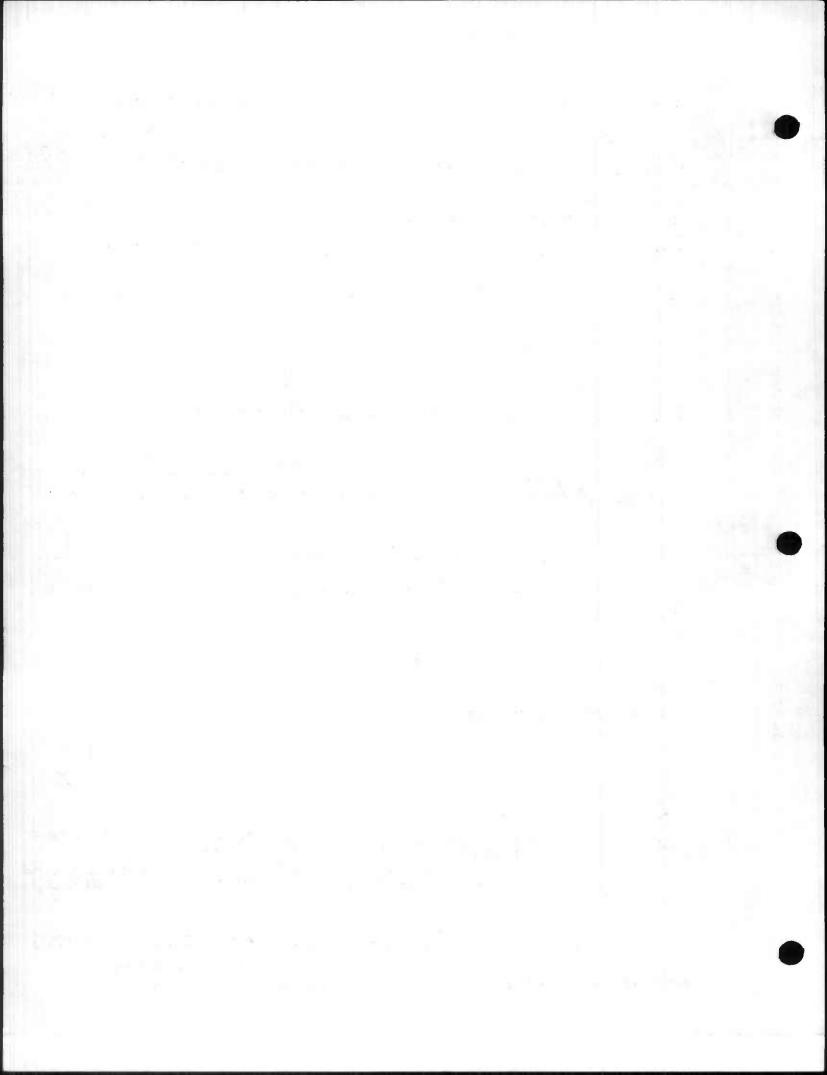
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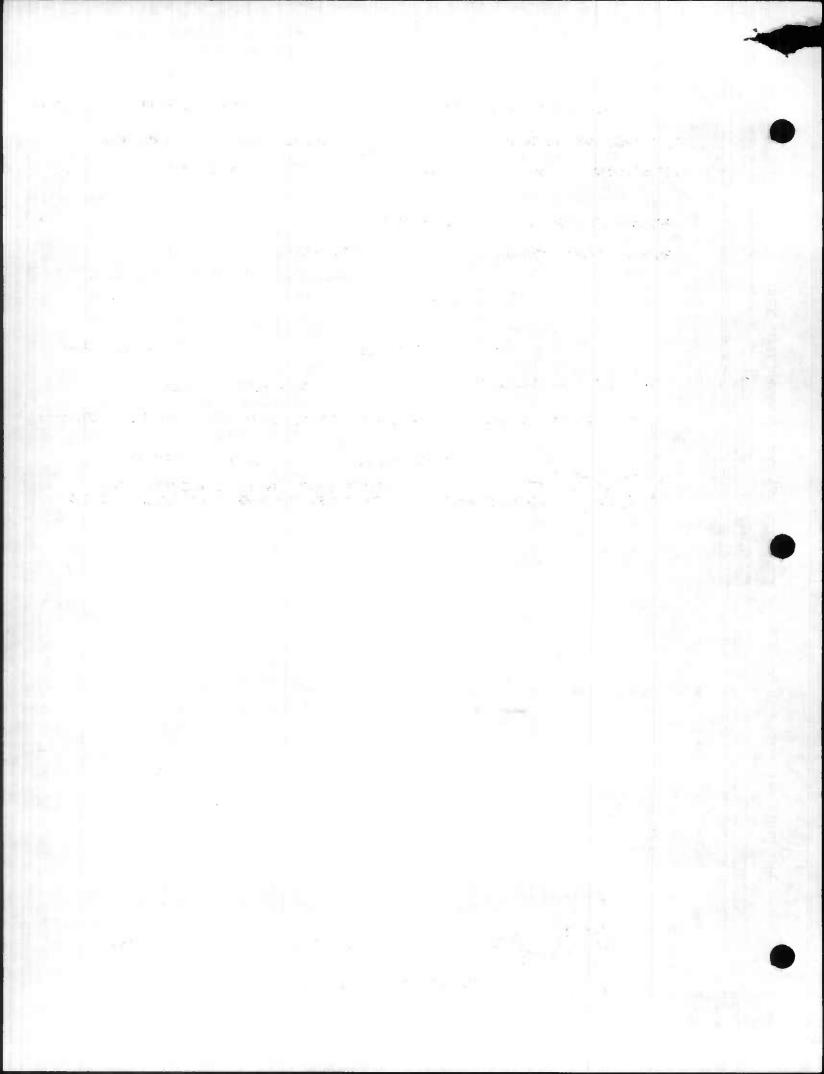
32. Registrar's Signature

1999



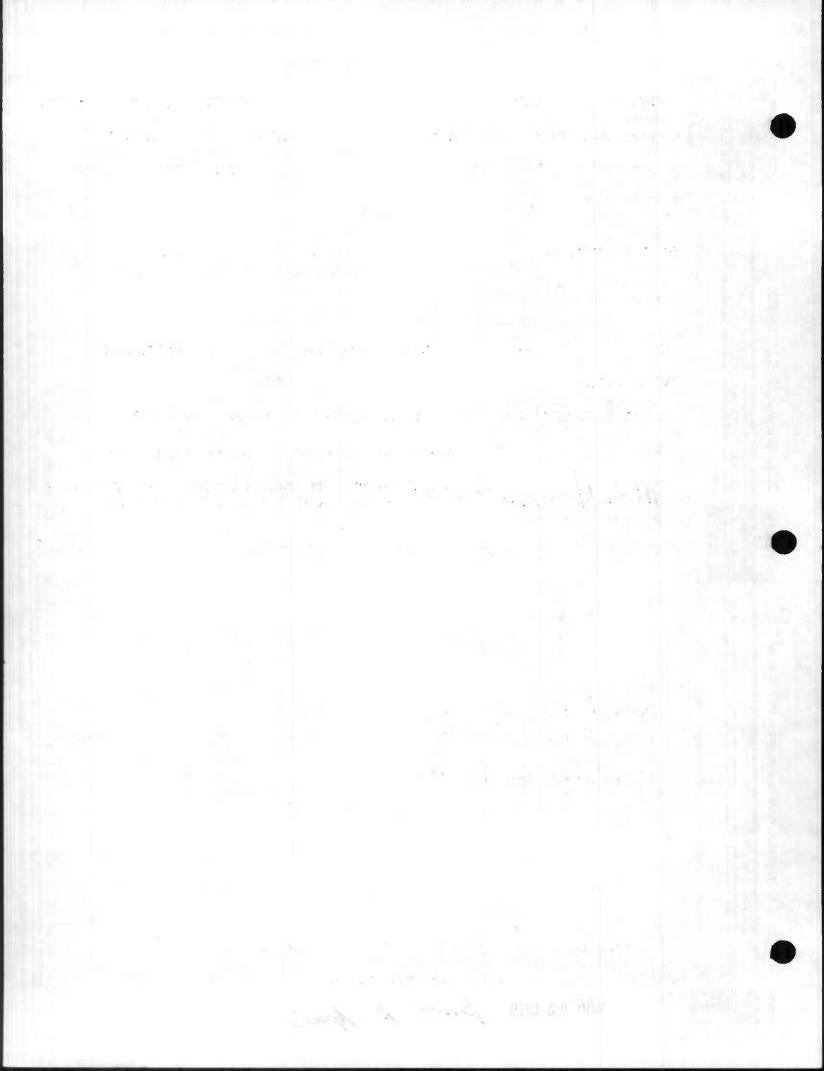
Piease Type or Print in Biack indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \ Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** FEB. 22, 1999 HOWARD GEORGE OBERLANDER 6:57 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 3505 EAST-WEST HIGHWAY CHEVY CHASE MONTGOMERY 8. Date of Birth 05. 12. 1911 If Under 1 Yeer If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (in yrs. last birthday) **Funeral** 1₽M 2□F Months Days Hours Min 87 Yrs. 221.07.0034 N.T Director Usual Rasidance of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Madical Examples must be notified at 1 ☐ Yes 2 ☐ No Directo CHEVY CHASE MARYLAND MONTGOMERY 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20815-5957 USA 3505 EAST-WEST HIGHWAY Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pagas 1 and 2 should be filed within 72 hours efter nant of Health and Mentel Hygiene.
nt: If Item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1□ Yes 2□No Specify: Specify: WHITE P 3 Widowed 4 □ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) MAGAZINE COMPANY TREASURER 18. Mother's Name (First, Middle, Maidan Sumame) 17. Father's Neme (First, Middle, Last) GEORGE FERDINAND OBERLANDER ANNA ROSALIE MILLER 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20815-5957 3505 EW HIGHWAY, CHEVY CHASE, MARYLAND ROBERT G. OBERLANDER/SON 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pagas Department of important: if it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2.27.99 STRATFORD, CT. UNION CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 DANIEL SIMONS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear militia. List only one cause on each lina. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition rasulting in daath) RENAL FAILURE Examiner Due to (or as a consequence of): Examiner CARCINOMA OF THE PROSTATE-METASTATIC physician and the burial-trensit Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Disaasa or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, that the death certificate be Physician/Medical Due to (or as a consequence of): 9 use ö signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown BRAINSTEM STROKE, Division of Vital Records, à 24b. Were autopsy findings available prior to completion of ceuse of daath? 24a. Was an autopsy performed? Completed page 2 s has 1 Yas 2 No certificate 1 T Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case rafarred to madical examiner? Be 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending aftar death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 2 4 Homicida C 24 hours a 10x Certifying Physician: To the best of my knowledge, death occurred at tha tima, date and place, and due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hospi within 24 hou To the Funer completely fil edical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of a 29c. License number 02.24.1999 D 26571 30. Nama and add was or person who completed ceusa of death (Itam 23a) (Type, Print) 4930 DEL RAY AVE, BETHESDA, MD IRVING MIZUS, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1999 MAR 02 Elmer.

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month **Physician** EUGENE LARRY 2, 1999 4:25am OSOLIN MARCH /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner WILLIAM HILL HEALTH CARE CENTER EASTON TALBOT 8. Dete of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Sex XXM 2□ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min Yrs 042-16-5197 85 OCT. 5, 1913 Director LATVIA Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 77 is marked other than "natural", or items 23a or 28a-f show traumetic event, the Modical Examinar must be notified at MD TALBOT EASTON Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 501 DUTCHMAN'S LANE pemit. Peges 1 and 2 should be filed within 72 hours after death v. Depertment of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner mans and DRCB. 21601 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ②XXNo if Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Status Bleck, White, etc. 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Specify: WHITE by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) -0-ESTATE CARETAKER MAINTENANCE 17, Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FRITZ OSOLIN VINA 10 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) EUGENE F. OSOLIN/ SON 12121 CHURCH LANE, CORDOVA, MD 21625 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SPRING HILL CEMETERY 3-5-99 EASTON, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical weum mia dwich **Examiner** Due to (or as a consequence of) Examiner attending physician and for use es the buriel-transit certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Box 68760 Physician/Medical Due to (or as a consequence of): use es i Pert II. Other-significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. 1 Yes 2 No 3 Probably 4 Unknown signed by Division of Vital Records, by 8 24b. Were autopsy findings available prior to Completed 24a. Was en eutopsy performed? peen completion of cause of death? 1 Yes 2 Tho rebrownscular 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Deeth 28a. Date of injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. injury at Work? Certification: Natural or Attending 5 Pending s efter deeth. 1 ☐ Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 4 Homicide Hospital 24 hours 11 certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end manner es stated. 29a. Certifier Medical completely 2 Medical Examiner: On the besis of axeminetion and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) within 2 To the the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 Mary 000 30. Name and address of person who completed cause of death (Item 239) (Type, Print) WILLIAM H. WOOD, JR., M.D., 506 IDLEWILD AVENUE, EASTON, MD 21601 MAR 0 3 1999 32. Registrar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 2 Date of Death Decedent's Name (First, Middle, Last) Physician MAR 2:30A.M. OHN EWIS /Medical 4b. City, Town, or Location of Deeth cility Neme (If not institution, give street end number) Examiner ROAD EW WIDSOR If Under 24 Hrs. 8. Date of B 3209 FFALO 8. Date of Birth (Month, Dey, Year) Age (In yrs. lest birthdey).
Yrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number **Funeral** 12M 20F Months Days 217-09-6565 (AY 16 1910 **Director** death with the Marylend 10a. State 10b. County 10c. Cify, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or items 23s or 28s-f show other traumetic event, the Medical Examinar must be notified at WINDSOR 1 Yes 2 No FREDERIC Directo 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 3209 21776

13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) KOAD Was Decedent Ever in U,S. Armed Forces? Funeral merican Indien. 11. Marital Status Black, White, etc permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Heelth and Mental Hygiena. Important: If item 27 is merked other than "natural, or item any injury or other traumetic event, the Medical page. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 Yes 2 No altimore, Maryland 21215-0020 Specify: Specify: WHHE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired)/
• 16b. Kind of Business/Industry Etementery/Seconda (0-12) College (1-4or 5+) ("ONSTRUCTION BUILDER 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Be ELIZABETH LEWIS VECHOLTER or Rural Route Number, City or Town, Stete, Zip Code) 192 Mailing Add Bss (Street and Number of PE NEW WINDS 01

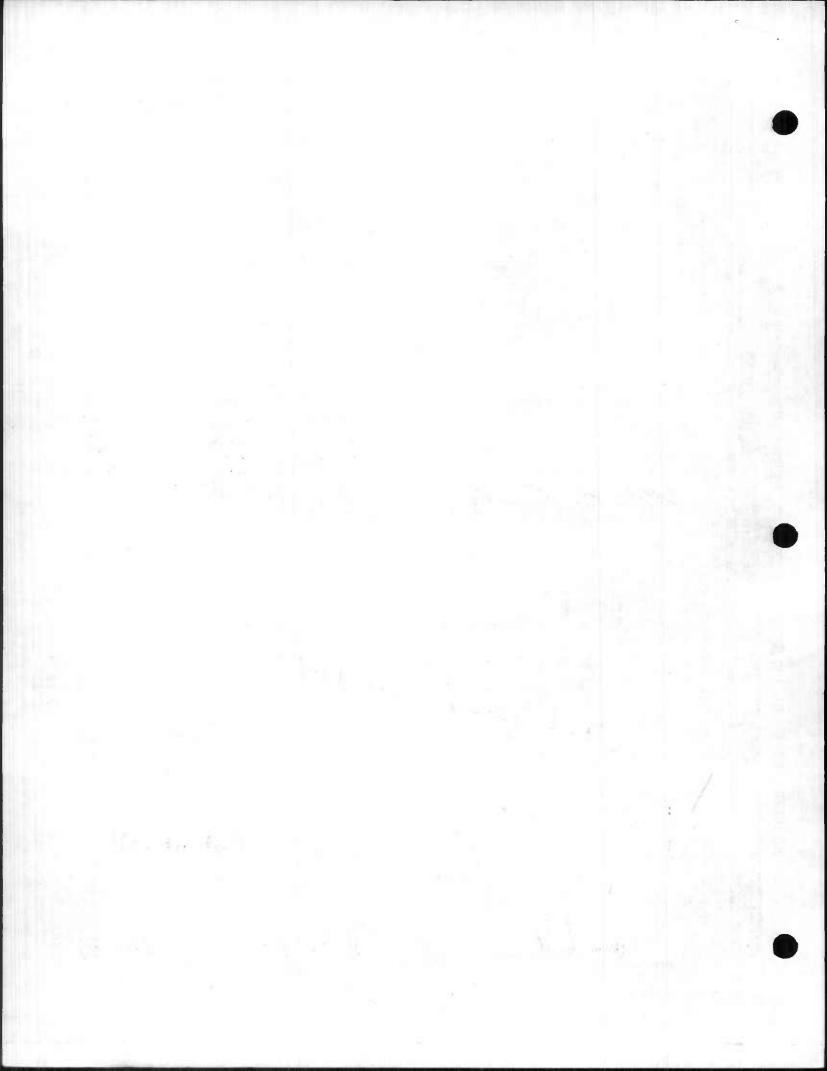
20b. Plece of Disposition (Name of cemetery, cremetory or other piece, KACHELM. OVERHULTEER 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility PRIHS 412 WASHINGTON ROAD 21. Signature of Juneral Service Licensee FUNERAL HOME & CHAPEL 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset end Deeth Physician Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Due to (or es e consequence of): Physician/Medical Examiner rostate Cancer ettending physician and for use as the burial-transit requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) P.O. Box 68760. Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? ed by the detached Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Onknown signed by Discase Division of Vital Records, À 24b. Were eutopsy findings available prior to completion of ceuse of deeth? 24e. Was en autopsy performed? Completed pege 2 s cartificata has 1 ☐ Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Thesidenca 2 1 Yes 2 Ho 3□ DOA 1 Inpatient 2 ER/Outpatient 6 ☐Other (Specify) Aftar this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Naturel 5 Pending 1 TYes 2 No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital 29e. Certifier 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and pleca, and due to the ceuse(s) end manner es stated. Medical completaly 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) end manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature end title of cartifu .0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 912 Washing for Rd Westmund Westmuster MD 21157 Washing ton 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 4 1999 Registrar

ONE CHAIN THE LEVELS ROOM LANGE BANK KEN WHILDRY KEELEDING Short Stewart Fife 1.5 WELLELL WEST AMAZER 84.27 Elements 4.142 Section Fred The state of the state of the A HA LEVY " FRANCE SE. WHILLES TO THE SERVE OF THE SERVE CAPIELAR HERCHOLEEL WHE TIEN WINGLES ALT WITH .

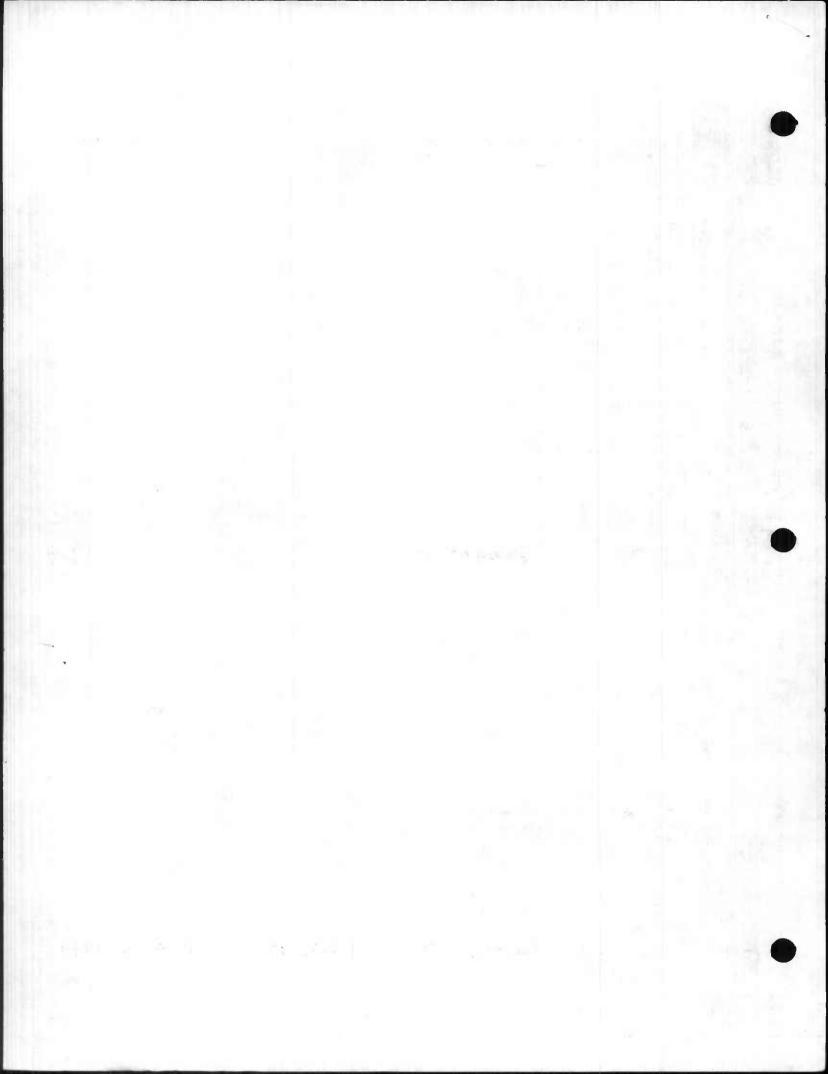
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day **Physician** Du Van Pham 22, 1999 3:50 P.M. February /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Washington Adventist Hospital Takoma Park Montgomery Hours Min. 8. Dete of Birth (Month, Day, Ye. Oct. 5, 1 If Under 1 Year 5. Sociel Security Number 7. Age (fn yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 15 M 20 F 1908 Yrs 586-50-2764 90 Director Vietnam Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Herre 23s or 28a-f show ner must be notified at 1 Yes 2X No Director MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9515 Lawnsberry Terrace 20901 USA Funeral 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married the Medical Examin Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Asian 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry filed within 72 Hygiene. other than Elamentary/Secondary (0-12) 12 College (1-4or 5+) Owner / Operator Store 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maidan Sumeme) pelmit. Pages 1 and 2 should be fits Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event Be Nhan Van Pham Quy Thi Mai 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) Thong Van Pham 14322 Stilton Circle, Silver Spring, MD 20905 20b. Plece of Disposition (Name of cametery, crematory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Metropolitan Crematory 2/24/99 Alexandria, VA 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Francis J. Collins Funeral 21. Signeture of Funerel Service Licensee Home, Inc. 500 University Blvd. West Silver Spring, MD 20901 23e. Perf1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on aech lina. Approximate Intervel Between Onset end Death **Physician** /Medical Immediete Cause (Final disease or condition resulting in death) 4 days Pneumonia Examine Due to (or es a consequence of) Examiner days Hypoxemia physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760 3 days Tachycardia Physician/Medical Due to (or es e consequence of): 6 days Fractured Hip signed by the at d be detached for P.O. Per Conditions of 23b. Did tobacco use contribute to the cause of death? ulting in the willerlying cause of buting to death but not t Yss 2 No 3 Probably 4 Unknown Division of Vital Records. þ The law requires 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24e. Wes an autopsy performed? page 2 hes 2 1NO 1 Yes 2 No 1 ☐ Yes 25. Wes case falerred to medical examiner? Attending Physician: Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 □ DOA this 27. Menner of Death 28b. Time of tnjury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 1 Naturel 5 Pending n 24 hours after death.

Ne Funeral Director: Alpletely filled in by the fu death. 1 ☐ Yes 2 No Atient Fel investigation 2 Accident 2-16-99 10:40 A. 6 Could not be detarmined 3 Suicide 28a. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28. Location (Street end Number or Rural Route Number, City or Town, Stata) 4 ☐ Homicide 6 9515 Lawnsberry Terr, S.S., MD Group Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end menner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only) 29c. License number 29d. Dete signed (Month, Dey, Year) Mto 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) Steven Fuller, M.D., 7600 Carroll Avenue, Takoma Park, Maryland 20912 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State MAR 02 Registrar



mend :	#6,3/2,	/99,BMW,Montgomery		Maryland /		tment o			nd Me		giene 9 9	0	8541	
		1. Decedent's Name (First, Middle, La	st)							2. Date of De	eth Day	Year	3. Time of Deeth	
	Physician /Medical	GUMERCINDA A	A. PA	ACQUING								1999	9:38 AM	
B	Examiner	4a Facility Name (If not institution, giv	re street and numb	ber)			4b	. City, Tow	m, or Loc	ation of Deat	h 4c. County	of Death		
100		Shady Grove Ad	dventis	t Hospi	tal		R	ockv	ill	е	Mon	tgom	ery	
Fu	uneral	Social Security Number 6. 8		. Age (In yrs. last b		If Under 1 \	Year Deys	If Under 2 Hours	4 Hrs.	B. Date of Bir (Month, De	th v. Year)	9. Birthp	lece (State or Foreign	
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anyle	or 28a-f show re notified at Director												0d. Inside City Limits 1 ☐ Yes 2 ☐ No	
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ŧ.	Dir.	10e. Street and Number				10f. Zip Co					10g. Citizen of \	Whet Coun	try?	
		18613 Flower Hill				208					United			
	al, or frame 23s or 28s-fs manifier must be notified by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Deced Armed Forc 1 Yes 2 If Yes, Give Year or Date	es? [X]No		es Deceden Yes, specify ☐ Yes 2☐		penic Orig , Mexican, Specify:	in? (Spec Puerto R	ify Yes or No ican, etc.)	Black Specify			
-00-		15. Decedent's E	ducation	16	a. Decede	nt's Usuel O	Occupati	ion			16b. Kind of B		<u> </u>	
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2121 d within piene.	THE WO	Elementary/Secondary (0-12)	College (1-4		Teacl	ner					Educ	ation	1	
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Id by	To 8	Fulgencio Paco	quing					Pr	coser	pina	Abay	a		
Baltimore, Maryland 21215-0020 pernit. Pages 1 end 2 should be filed within 72 hours at Department of Health and Mentel Hygiene.	E	19a. Informant's Name/Relationship (Type, Print)	19	b. Mailing	Address (S	itreet en	nd Number	or Rural	Route Numb	er, City or Town,	Stata, Zip	Code)	
E pud 5	27 le r tre	Eleanor Zabala,	Grand-da	ughter 1	8613	Flowe	r H	i11 V	lav.	Gaithe	ersburg.	MD	20879	
F. F.	e dip	20a. Method of Disposition		20b. Place	of Disposi	tion (Neme	of			Data	20c. Location			
DE Sage	Y 27	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		210						b 27,	A 1 1		Winds is	
F	The same	21. Signature of Funeral Service Licer	/	Metro	-	tan Cr				999			Virginia	
	any i	Devoi rune												
p)		23a. Parth. Enter the disease, or com shock, or heart fullum. List only	/ Jus								Lthersbu	rg, N	ID 20877 Approximate	
/Me	sician edical miner	Immediate Cause (Finel disease or condition resulting in death) Due to (or as a consequence of):										1	Onset end Death	
8760, ate be asscuted	hysician and the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.												
	£ 5 TO													
O. E	sici	Part II. Other eignificant conditions of	ontributing to deal	th but not resulting	in the und	lerlying caus	se giver	n in Pert I.		23b. Did tobacco use contribute to the cause of de				
S, P.O.	D S									10	Yes 21 No	3 Proi	bably 4 ☐ Unknow	
of Vital Records, Physician: The law requires the	page 2 should Completed							4	_		en eutopsy ormed?	CO	ere autopsy findings eilable prior to mpletion of cause death?	
E .	Cor Cor							100		10	Yes 22 No	1[Yas 2□ No	
Vita	rector, pag	25. Was case referred to medical examiner?	Manatati				1 -		of Deeth	(Check only	ona)			
To the	this cel dire	1 ☐ Yes 2€ No	Hospital:			3□ DOA	Other	4 LI Nun	-	-	dence 6 □Oth		y)	
C .	After funer lon	27. Manner of Death 1. Natural 5 ☐ Pending 2. Accident investigation 3. Suicide 6 ☐ Could not b	n	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 U Yes 2 U No								I Route Number,		
Division To the Hospital or Attend within 24 hours after deet	To the Funeral Directompletary filled in by Medical Certif	4 Homicide determined	building	f Injury - At home, i , etc. (Specify)						City or To	wn, Stata)			
Hos.	Fun staty	29a. Certifier the Certifying Ph (Check only one) 2 Medical Exam	ysician: To the be niner: On the basi and manne	est or my knowledg is of examination a	ge, deeth o ind/or inve	stigation, in	my opi	nion, deeth	piace, ei	d at the time,	data end plece,	and dua to	the cause(s)	
thin the	Mec	29b. Signature-and title of Cartifier	anu manne	stated.		29c 1	icense	number			29d. Date signe	d (Month	Day, Year)	
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9	3	Man & XIC	raelu	y rui	0		120	,54	Ü		LED.	46	1999	
		30. Name and eddress of person who Carl I. Schoenber	ger, M.D	., 16220			Ro	ad, C	Gaith	ersbui	eg, MD	20877		
R	State Registrar	31. Date filed (Month, Day, Year) MAR 0 1	999 32. Reg	Strar's Signature	B.	Spo	nk.	2						



99-1126-031

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Months

ARMAND	∞	State of Maryland	/ Department of Health and Mental	Hygiene C)
PEREZ	Amend	#7,3/3/99,BMW,Montg.Co	Certificate of Death	Reg. No.	

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0	100	10		

Physician
/Medical
Examiner

Director

Funeral

by

Completed

Be

Physician/Medical Examiner

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Completed

Be

P

Certification:

edicai

ARMANDO VALLADARES PEREZ

2. Dete of Deeth 26, 1999 FEBRUARY

3. Time of Deeth

4a Facility Neme (If not institution, give street and number)

4b. City, Town, or Location of Deeth

4:52P.M.

Funeral

RT.355 & E.DIAMOND AVE 5 Social Security Number M 20 F

7. Age (In yrs. last birthday) Yrs. 36

Hours Min. 8. Date of Birth (Month, Dey, Ye) 08-27-62 If Under 1 Year Deys

 Birthpiece (State or Foreign
Country) EL SALVADOR

Director

the Merylend

permit. Pages 1 and 2 should be filed within 72 hours efter death with Department of Health and Mentel Hygiene.
Important: If Item 27 is marked other than "natural", or flems 23s or a small higher or other traumatic event, the Medical Examination and

Physician

/Medical Examiner

ettending physician end for use es the buriel-transit

signed by the e

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After

d in by the

death.

efter

To the Hospital o within 24 hours eff To the Funeral Di completely filled in

98

The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

or Attending Physician:

Baltimore, Maryland 21215-0020

10a State 10b. County MARYLAND MONTGOMERY

1. Decedent's Nama (First, Middle, Last)

10c. City, Town or Location

10d. Inside City Limits

10e. Street and Number

622-44-8402

Usuel Residence of Decedent

SILVER SPRING

1 Yes 2 No 10g. Citizen of What Country?

11504 LOCKWOOD DRIVE #A1

20904 Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.)

10f. Zip Code

EL SALVADOR 14. Race - Amarican Indian.

1 Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedant Ever in U,S. Armed Forcas? 1 Yas 2 No If Yes, Give Yeer or Detes:

X Yes 2 No Specify: EL SALVADOR

Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry

4c. County of Deeth

MONTGOMERY

DISH WASHER

RESTAURANT

17. Fether's Name (First, Middla, Last)

STEVEN VALLADARES

EMMA PEREZ

19e. Informent's Name/Reletionship (Type, Print)

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 5536 SIERRA VISTA AVE. LOS ANGELES, CA. 90038

JOSE N. PEREZ

20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition

20c. Location - City or Town, Stete

1 Burial 2 Cremation 3 Ramoval from State 4 Donetion 5 Other (Specify)

NATIONAL EUNERAL HOME

03-83-

18. Mother's Name (First, Middle, Malden Sumeme)

FALLS CHURCH, VA.

22. Name and Address of Fecility
AFFORDABLE FUNERAL SERVICES DUNN LORING, VIRGINIA 22027

23a. Pert1. Enter the disease, or complications that consed the deeth. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heer teilure. List only one cause or each line.

Immediate Cause (Final disease or condition resulting in deeth)

Mulhole Due to (or es e consequence of)

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest

Due to (or es e consequence of)

Due to (or as e consequence of):

Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknown

24e. Wes en eutopsy performed?

24b. Were eutopsy tindings aveilabla prior to completion of causa of death?

Approximata Intervel Between Onset and Daath

1 PYes 2 □ No

1 PYes 2 □ No

25. Was casa referred to medical 1 X Yes 2 □ No

5 Pending investigation

6 Could not be determined

forler

27. Manner of Death

1 Naturel

2 Accident

4 Homicide

3 Sulcide

Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (2011) 8b. Time of Injury

2-26-99

16 49

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE 28d. Dascribe how Injury occurred 505/ect

Shur 50

26. Plece of Deeth (Check only one)

wan 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) Viamand

29e. Certifier (Check only one)

David

Railroad 355 4 Wacks RH 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner and manner and the cause(s) and manner and manner.

29b. Signature end title of certifier

29c. License number

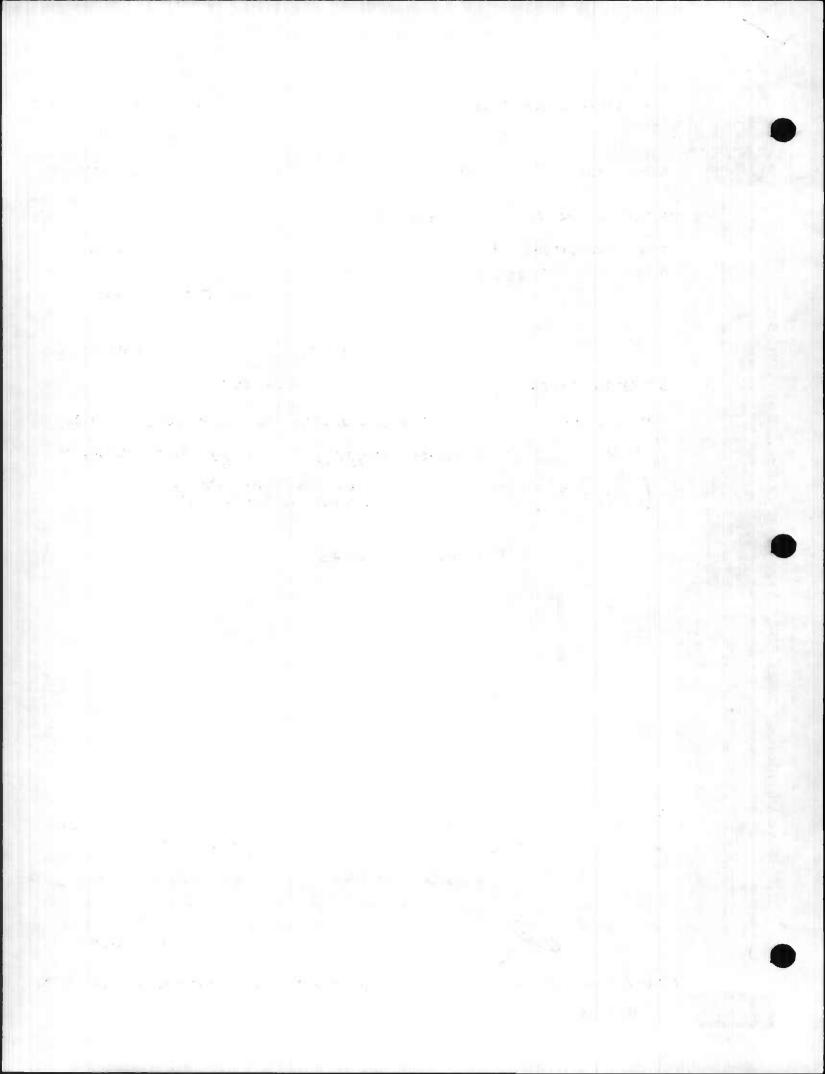
O.C.M.E.

29d. Data signed (Month, Day, Year) FEBRUARY 27, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

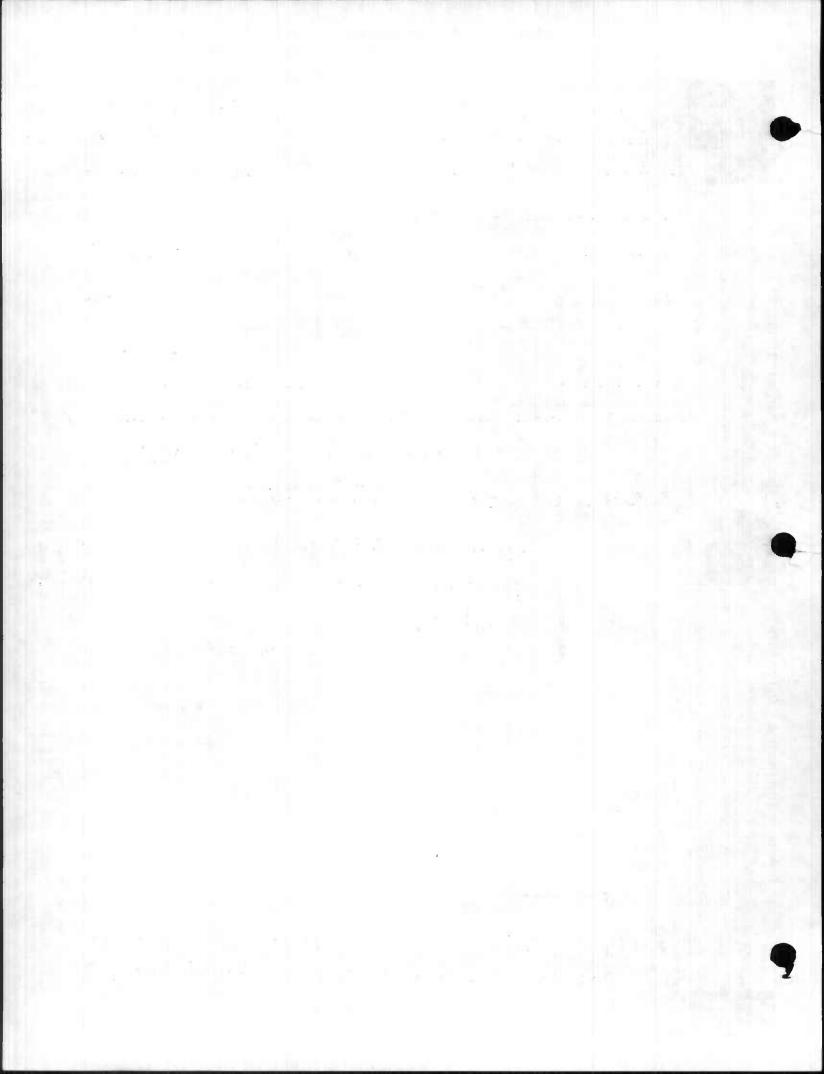
State Registrar 31. Date filad (Month, Day, Year) MAR 03 1999 32 Registrar's Signetura

111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene 9 0 0 5 1 3

			Decedent's Name (First, Middle	e, Last)		Cer	tificate of	Dealli	2. Dete of D	Reg. N			3. Time of Deeth	
	Physicia /Modis		Ella		erce				Febru	arv		999	8:45 PM	
1	/Medic Examine		4a Fecility Name (If not institution	^ .		, ,		4b. City, Town, or		th / 4	c. County of	Death		
L					Hospi		W. 11	Lau			Princ		seorge's	
	Funeral Director		5. Social Security Number 227-07-7413 Usuel Residence of Decedent	6. Sax 7. 1 □ M 2 F	Age (In yrs. 84	lest birthdey) Yrs.	If Under 1 Yee Months Deys		8. Date of Birth 9. Birthplaca (State or Foreign (Month, Dey, Yeer) 9. Birthplaca (State or Foreign Country) September 27,1914 Virginia					
	wo w	-	10e. Stete 10b. County		10c. Cit	y, Town or Loc	cation					10	d. Inside City Limits	
	a-f sh	cto	Maryland Prince	George's	Lau	re1							¹Ã Yes 2 No	
	ath with the Marylen 23a or 28a-f show	ral Director	10e. Street end Number 3329 Valley Lee	Street			10f. Zip Code 20724			Uni	itizan ot Whe ted St f Amer	ates	y?	
020	urs e	by Funeral	11. Merital Status 1 Never Merried 2 Marr 3 Widowad 4 Divorcad	11.14	S? No		Vas Decedent of Yes, specify Cu ☐ Yes 2 No	Hispanlc Origin? (S ben, Mexican, Puarl Specify:	pecify Yas or N o Rican, atc.)	0-	14. Race - Bleck, 1 Specify:	White, et	tc.	
21215-0020	within ane.	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	t's Education st grede completed) College (1-4c	or 5+)		ent's Usual Occu kind of work done O NOT use retire	upation e during most of wor ed)	rking		Kind of Busin		stry	
Maryland 2	d oth	e	17. Fether's Name (First, Middle, William Dow Hur					18. Mothar's Nar		, Maide	n Sumema)			
Mary	nd 2 shou aith and M 27 is mer r traumat		19e. Intorment's Name/Reletions Patricia H. Wil		ster		-	etend Number or Au Lee Stree					20724	
altimore,	Pages 1 e nent of Hea int: If item iry or othe		20e. Method of Disposition 1 🖾 Buriel 2 🗆 Cremetion 4 🗆 Donation 5 🗀 Other (S)			emetery, crem	sition (Name of setory or other pl Cemeter	ece)	larch 6		location - Cit thevil rginia	v or Tow le,	n, Steta	
Balt	permit. Page Depertment of Important: If any Injury or once.	21. Signatura of Funerel Service Licensee 22. Name end Address of Fecility Grubb Funeral Home Wytheville, Virginia												
		23a. Part 1 Enter the disease, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or respiratory errest, interest, inte												
	Physician /Medical Examiner	Immediate Ceuse (Final disease or condition resulting In deeth) e. Massive Myvardiad In Jarch'm Due to (or es a consequence ot): Bildru Pneumonin, Hypoxem's Dua to (or as a consequenca ot): July Preumonin, Hypoxem's Dua to (or as a consequenca ot):											Minutes.	
	pet lisit												15days	
Ú	execuin and hel-train	Exar	Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es a consaquanca of): Due to (or es a consaquanca of): Available and Hyportemore Henry Open 15 year											
	O1 00 .	8											15 years	
Вох	the death cery the attendir	Clan						1						
, P.O.	that the death cer led by the attendin detached for use	y Physician/N	Pert II. Other significant condition	ns contributing to death	but not resu	ulting In the un	deriying cause g	iven in Pert I.				Dute to t	the cause of death?	
Records,	been s	Completed by							24e. We perf	s en eut ormed?	opsy 2	avei	e eutopsy tindings lable prior to pletion ot cause seth?	
	iclen: The law certificate hes rector, page 2	EO							10	Yes :	2) No	1 🗆	Yas 2 No	
Vital	ysiclan: is certific director,	e D	25. Was case reterred to medical examinar?	I tono itali				26. Plece of Dee	eth (Check only	one)				
ot	S 80	0	1 ☐ Yes 2 ☐ No 27. Manner ot Deeth	Hospital: 1 Ninpa		ER/Outpatient 28b. Time of	3□ DOA 28c. Inje		loma 5 ☐ Res			(Specify)		
Z	fung fung	ILION	1 Netural 5 Pendin 2 Accident investig	g (Month, I	Dey Year)	Injury	W	ork? □Yes 2□No	200. Describe	11041 111	ary occurred			
Division	al or Attendi s after death I Director: A od in by the f	Certification:	3 Suicide 6 Could r 4 Homicide determ	ined 28a. Place of	Injury - At ho etc. (Specify		et, fectory, office	•	28f. Location City or To	(Street e wn, Ste	and Number (or Rurel	Routa Number,	
	n 24 hour in 24 hour in Pletely fil	edical	29a. Certifier (Check only one) Certifyin 2 Medical I	g Physician: To the bes Examiner: On the basis end menner	ot examinat	wledge, deeth tion end/or inv	occurred et that estigetion, in my	time, date end placa opinion, deeth occu	, end due to the irred et the time	cause(, date e	s) end manno nd plece, end	er es ste I due to t	ted. he ceuse(s)	
	withi To th		29b. Signature and title of certifier	jurla			DI	3671			ate signed (A	-19		
			30 Neme end eddress of person of the second	WALA M	deeth (Item	23e) (Type,	Print) wel	Park Dv.	Laure	l N	W ar	70'	7.	
	State	9	31. Dete tiled (Month, Day, Year)	999 32. Jegis	strer's Signe	-	loo V	4						



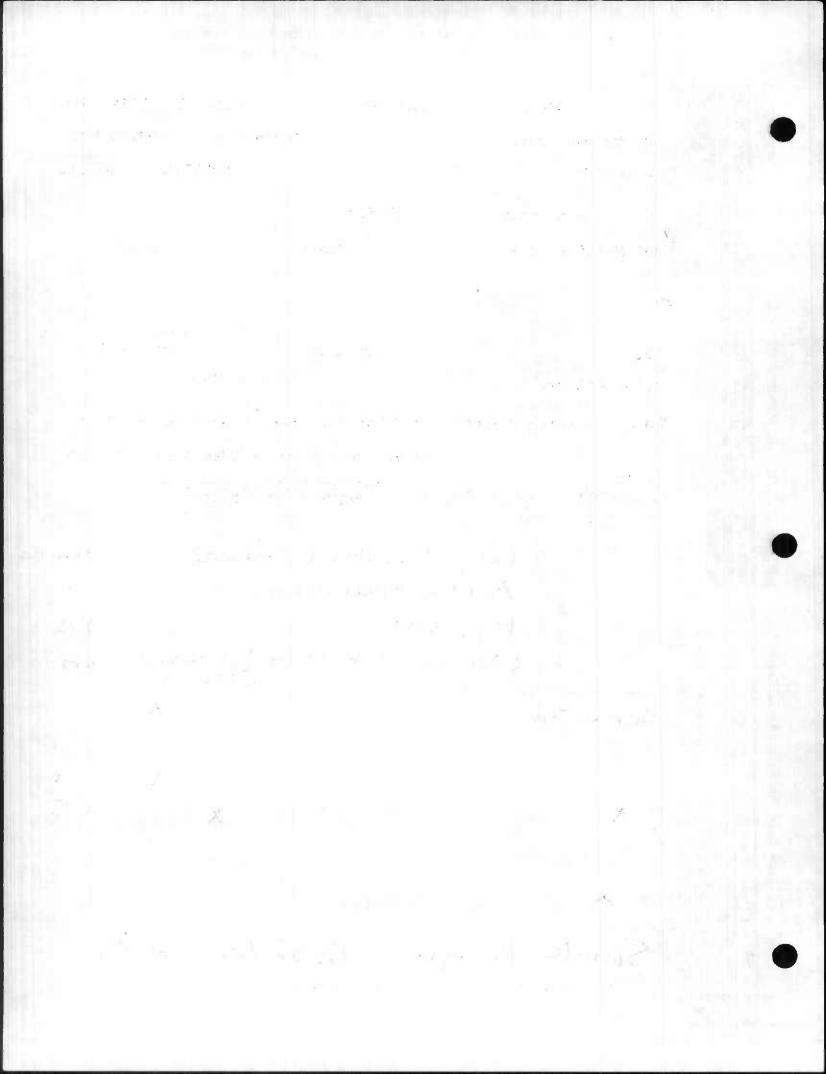
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3 Time of Death **Physician** FEB. 1999 28° 9:50 PM PRATHER A. BERNICE /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Rockville MONTGOMERY 200 Martins Lane | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June 23,1920 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 KF Yrs. 78 Maryland 579-44-0517 Director Usual Residence of Decedent with the Meryland permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any higher or other traumatic event, the Medical Eventual traumatic another page. 10e. Steie 10b. County 10c. City, Town or Location 10d. inside City Limits Rockville Yes 2 No Montgomery MD Director 10f. Zip Code 10g. Citizen of Whai Country? 10e. Street and Number U.S.A. 200 Martins Lane 20850 Funeral 12. Wes Decedeni Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No if Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marijai Staius 1 Never Married 2 Married Specify: Black 1 Yes 2 No Specify: þ ₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent'a Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Montg. Co. Elementary/Secondary (0-12) Coilege (1-4or 5+) Board of Ed. Registrar 12th 18. Mother's Name (First, Middle, Malden Sumeme) 17. Father's Name (First, Middle, Last) Annie Wims Allen Gilmore 19a. informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 202 Martins Lane, Rockville, MD 20850 Claude A. Prather (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Mem. Park 3/6/99 Rockville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature de Funeral Service Lice 22. Name and Address of Facility
SNOWDEN FUNERAL HOME, P.A. 20850 ROCKVILLE, MD 23a. Part1. Enter the data se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fature. List only one ceuse on eech line. Approximete Interval Between Onset and Deeth Physician /Medical immediate Ceuse (Final disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed physician end the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enier Underlying Cause (Disease or injury that initiated events resulting in death) Lesi P.O. Box 68760. Physician/Medical 98 use Use Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. ed by the a 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ementia Division of Vital Records, ð 24b. Were eutopsy findings eveileble prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate has b lirector, page 2 s 1 Yes 2 No or Attending Physician: director, 25. Wes cese referred to medicei exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Injury at 28d. Describe how injury occurred 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatieni 3 ☐ DOA this funeral 28a. Date of injury (Month, Dey Year) 27, Menner of Death 28b. Time of 28c. injury at Work? After Netural 5 Pending n 24 hours efter deeth.

The Funeral Director: After pletely filled in by the fun 1 Yes 2 No 2 Accident investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Phyaictan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifie npletely (Check only one) within 2 To the I 29b. Signature and title of certifier 29d. Dete signed (Month, Day, Year) TO 9 30. Name and address of person who completed ceuse of death (lem 23a) (Type, Print) 809 Veins Mill 20 Roc 32. Registrar's Signature 31. Dete filed (Month, Day, Year) 1999 MAR 02 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death 24, 1999 Month **Physician** February Mary R. Pulliam 9:55 PM /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Maple Ridge Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□ M 21XF 296-10-2812 80 Director Aug. 27, 1918 Ohio Usual Residence of Decedent 10b Counts 10c. City, Town or Location r 28a-f show notified at 10d Inside City Limits with the Marylar 1 Tyes 2 XNo Director Rockville Montgomery 10e Street and Number 10f. Zip Code 10a. Citizen of Whet Country? Berns 23s or 20853 4313 Prince Road USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, 11 Merital Status Bleck. White, etc. 1 2 Yes 2 No
If Yas, Give
Yeer or Detes: WWII 72 hours after 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 'natural', or 1 Yes 2 No Specify: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Public Safety/ Elementery/Secondery (0-12) 12 College (1-4or 5+) Own Home Crossing Guard / Homemaker 18. Mother's Neme (First, Middle, Meiden Sumeme) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Ilem 27 is married other any injury or other traumatic event adds. 17. Father's Neme (First, Middle, Last) Be Charles Reed Amelia Katherine Wilhelm 2 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine P. Berry (daughter) 4313 Prince Road, Rockville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State Gate of Heaven Cemetery 3/2/99 Silver Spring, MD

22. Name and Address of Facility Francis J. Collins Funeral
Home, Inc. 500 University Blvd. West 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licansee 20901 Silver Spring, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel Apiration Pneumonia old disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Dysphagia old sician and burial-transit The law requires that the death certificate be assouted Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Dementia Severe old Physician/Medical the Due to (or es a consequence of): signed by the at d be deteched to Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown py 24b. Were autopsy findings eveilable prior to Completed 24a. Was en autopsy completion of cause of death? page 2 has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospitel: Other: 4

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 XNo Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA After this funeral 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 StNeturel 5 Pending hours after death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined To the Hospital or Atter within 24 hours after der To the Funeral Director completely filled in by th 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner es stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the cause(s) end manner steted. 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 26, 1999 D31319 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Loreto S. Albiol, M.D. 8218 Wisconsin Avenue, , Bethesda, MD 20814

State Registrar

P.O. Box 68760.

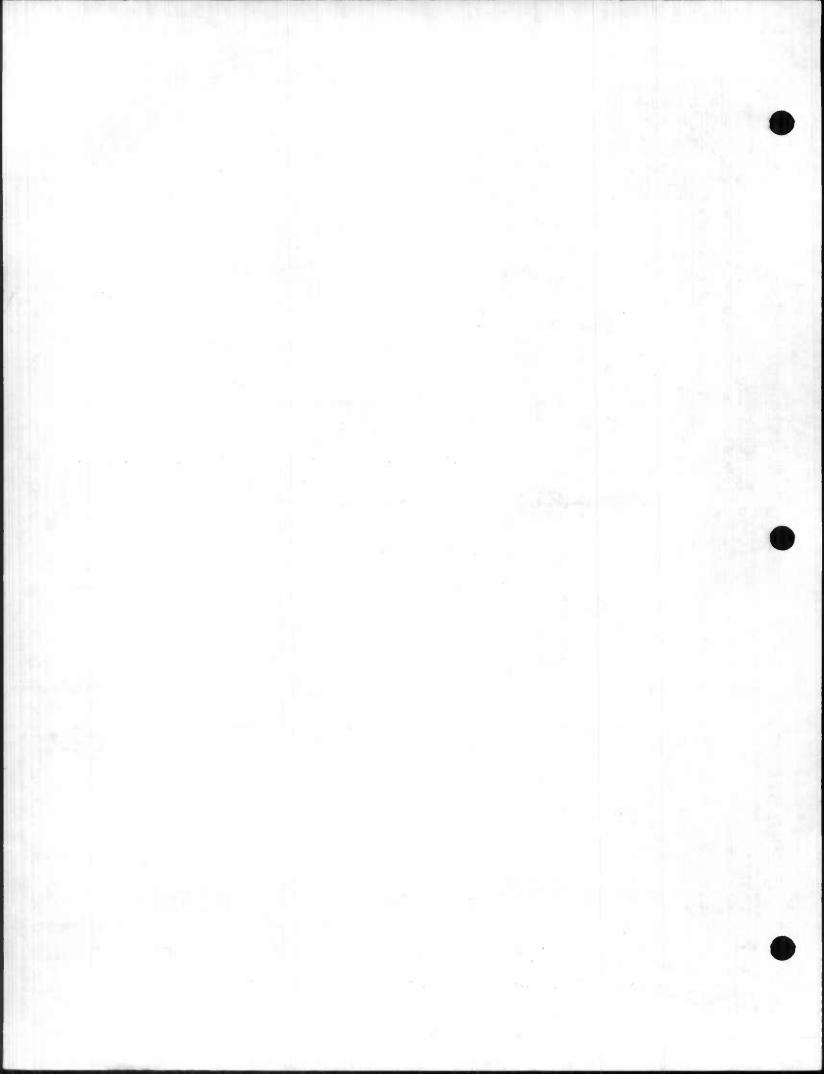
Records.

Division of Vital

DHMH 16 Rev 6/95

31. Dete filed (Month, Dey, Year)

32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month 3. Tima of Death **Physician GEORGE** ROBERT PENNINGTON, JR. February 25, 1999 19:15 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Harford Havre de Grace If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 24, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 10XM 2□ F Yes Director 69 1930 Maryland 212-28-0885 Usual Residence of Decedent 10a. Sfata 10b. County 10c. City. Town or Location 10d. Inside City Limits show or items 23s or 28s-f shor XXYes 2 No Directo Harford Maryland Havre de Grace 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 713 N. Stokes St 21078 USA Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 Never Married 2 Married 1 XYas 2 No If Yes, Give 1 Yes 2 No Specify: White If Yes, Give Year or DatesUNK . Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Haalth and Mental Hygiena. College (1-4or 5+) Elamentary/Secondary (0-12) Funeral Director Funeral 17. Father's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Ethel Porter George Robert Pennington, Sr. Sarah 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 713 N. Stokes St., Havre de Grace, Maryland 21078 Hem 27 George R. Pennington/Son altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 6 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State flon 5 Other (Specify) Hilltop Service Corp. 3-2-99 Towson, Maryland 21. Sign of Funeral S Name and Address of Facility
HOWARD K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disaasa or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last and Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of) USB signed by the a Part II. Other significant conditions confributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Linknown Completed by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was en eutopsy performed? 1 Yes 2 No 1 Yes 2 No Vital Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Tyes 2 LNO 1 Inpafienf 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury st Work? 28d. Describe how injury occurred Division Attending 1 Matural 5 Pending investigation 1 Yes 2 No death. 2 Accidant Director 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ŏ 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier complataly (Check only one) within 2 29b. Signature 29d. Data signed (Month, Day, Year) 29c. License number

State Registrar

128

31. Date filed (Month, Day, Year)

30. Nami

ss of person who complete

9 Roth Registrar's Signature

cause of death (Item 23a) (Type, Print)

319

South Union AVENUL HAVRE DE GRACE MARYLAND

25,1999

Robert Jr

George

aton

CUUUS

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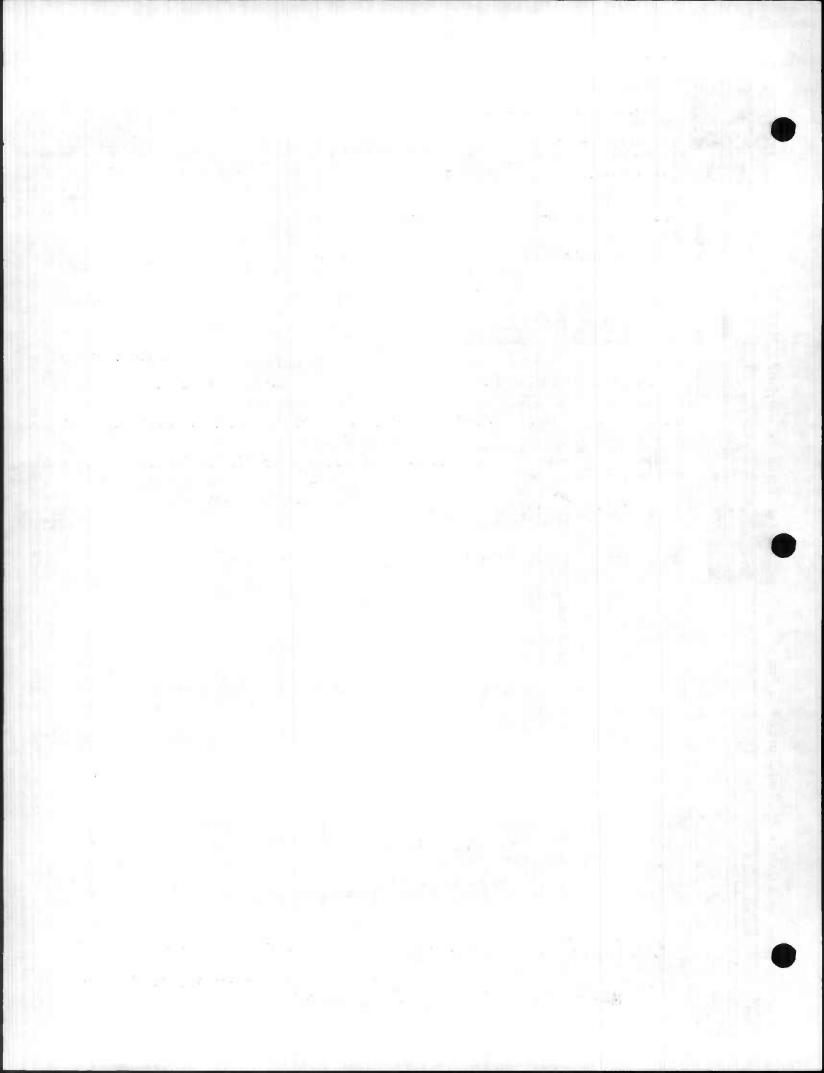
Hell 0 = High

99-1189-025 crn Meli

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 08547

1. Decedent's Nam	ne (First, Middle, La	ist)		N	Death	2. Date of Dea			Time of Death		
Moli	cca Cuo I	Connincton				Month	Day	Yeer	35 P.M.		
					4b. City, Town, or L				Palla		
Wawa Sto	re, Route						Har	ford			
216-96-	0764			Months Days		8. Dete of Birth (Month, Dey Mar. 30	7 Year) 0, 1980	9. Birthplece Country) Mary La	(Stete or Foreign		
			10c. City, Town or	Location				10d. l	inside City Limits		
MD		ord							1 □ Yes X No		
10e. Street and Nu	mber			10f. Zip Code			10g. Citizen of W	Vhat Country?			
100 S	œsutia R	load		210	01		II.S.A				
11. Marital Status	ried 2 Married	12. Wes Decedent Armed Forces'	t Ever in U,S. 1: ? No	3. Was Decedent of I If Yes, specify Cub	Hispenic Origin? (Spen, Mexican, Puert	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race Blac	e - American II k, White, etc.			
(Sne			16a. De	16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. Do NOT use retired) Clerk 18. Mother's Name (First, Middle, Maiden Sumeme) Cynthia Ann Horn 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 100 Spesutia Road, Aberdeen, Maryland 21001 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Harford Memorial Gardens 3/5/99 Aberdeen, Maryland 22. Name end Address of Feolity Tarring—Cargo Funeral Home, P.A. Aberdeen, Maryland 21001—3399 he set the Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwo							
Elementery/Seco			5+) life	DO NOT use retire	d)	naig					
17 Fethor's Name	/First Asiddle 1	0	Cl	erk	10 Matheda Mar	o /First ##Iddl	Convenie	ence St	ore		
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-			106.44				State 7in Co.	10)			
		ocep racile	20b. Place of Dis	sposition (Neme of							
					1	0 /= /00					
		**	Harioro	22 Name and Addr	ass of Facility			n, Mar	yland		
1		10/	7	Tarring-	Cargo Fun						
23a Part1 Enter	the disease or con	nolications that cause	od the stally Do not					An	provimete		
shock, or hea	art feilure. List only	one ceuse on eech l	line.	onto the mode of dy	ing, oboit oo baraia	or roopilatory and		Inte	erval Between set end Deeth		
Immediate Cause	(Final	40	1111			10					
disease or condition resulting in death)	on	e. /// /			T WOU	inas		1			
= 1,2 11			and to for as a cons	ouquerioe orj.							
Sequentially list co	onditions,	b	Due to (or as a cons	sequence of):							
if any, leading to in cause. Enter Under	mmediate erlying							i I			
thet initiated event	s Lest	C	Due to (or as a cons	sequence of):							
		d									
		d									
	ficant conditions		but not resulting in the	e underlying cause gi	ven in Pert t.	23b. Dld t	obecco uee cor	ntribute to the	e cause of death?		
	ficant conditions		but not resulting in the	e underlying cause gi	ven in Pert t.	23b. Did t			e cause of death?		
	ficant conditions of		but not resulting in the	e underlying cause gi	ven in Pert t.	101	res 2⊠No	3 Probabl	y 4□Unknown		
	ficant conditions of		but not resulting in the	e underlying cause gi	ven in Pert t.	1 🗆 1	res 2⊠No	3 Probabl	y 4 Unknown autopsy findings ble prior to ation of cause		
	ficant conditions of		but not resulting In the	e underlying cause gi	ven in Pert t.	1 N	es 2X No en eutopsy med?	24b. Were e eveilab comple of deat	autopsy findings ole prior to stion of cause th?		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death Month BARRON WILLIAM POWERS 28, 1999 2:30 AM February 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 26961 Yowaiski Mill Road Mechanicsville St. Mary's If Under 1 Year | If Under 24 Hrs. 8 Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplaca (State or Foreign Country) 1ØM 2□ F 60 Months Yrs. 1938 578-48-4057 Washington DC Usual Residence of Decedent 10c. City, Town or Location 10d. inside City Limits 10b. County 1 Yes 2 No Maryland St. Mary's Mechanicsville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 20659 USA 26961 Yowaiski Mill Road 12. Wes Decedent Evar In U.S. Armed Forces? 1 Ø Yes 2 □ No ARMY If Yas, Give Yeer or Detes: 1962 - 74 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Status Bleck, White, atc. 1 ☐ Nevar Married 2 € Married 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Supervisor Printing Company 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Eugene Powers Dorothy Flynn 19e. Informent's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26961 Yowaiski Mill Road, Mechanicsville, MD 20659 Carol M. Powers - Wife 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burial 2 Ø Cremetion 3 ☐ Ramoval from Nuntt/Lrematory 4 ☐ Donetion 5 ☐ Other (Specify) 3/2/99 Waldorf, Maryland 22. Name and Address of Facility Huntt Funeral Home, Inc. 21. Signeture of Funeral Service Licensee 23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete intervel Between Onset end Deeth Immediata Cause (Finel disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Pert II. Other significant conditions contributing to deeth but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 PYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yes 2 PNo 1 ☐ Yas 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

10e. State

Funeral

Director

28a-f show

6

Нета 23а

Director

Funeral

þ

Completed

other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Item eny Injury or other traumatic event, the Medical Fran

Baitimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

Examine physician and s the burial-trans Physician/Medical 88 þ Completed Be 2 edical Certification:

The law requires that the death certificate be executed ed by the detached signed by t After this or Attending n 24 hours after death.

• Funeral Director: Afte pletely filled in by the fur Hospital

25. Was case referred to medical examiner? 1 Yes 2 No

29e. Certifier (Check only one) 29b. Signeture of title of certifier

27. Menner of Death

1 Neturel 5 Pending investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide

6 Could not be determined

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year)

28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury et Work? 1 Yes 2 No

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

26. Place of Deeth (Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year)

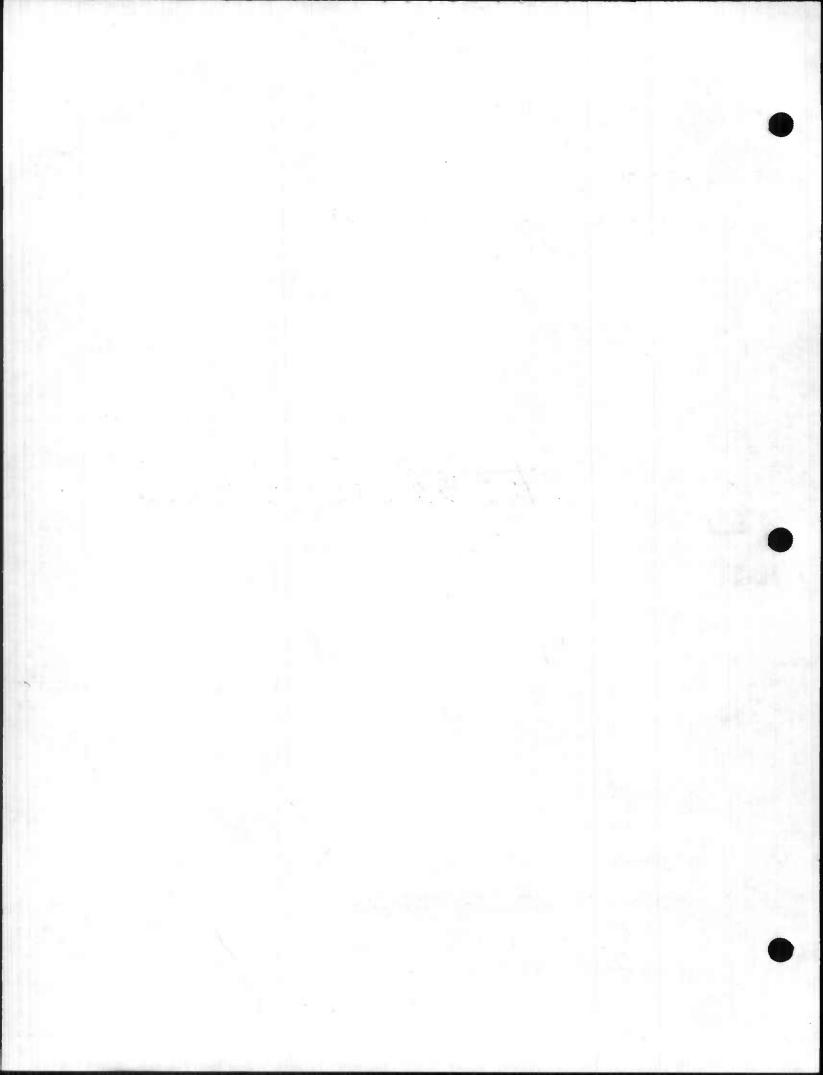
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Dr. G. Shankar Rath, 7-C Post Office Road, Waldorf, MD 20602

State Registrar 31. Date filed (Month, Dey, Year) MAR 05

32. Registrar's Signeture

To the I within 2



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Elizabeth March 4, 1999 Pusey 7:15 PM 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Salisbury, Salisbury Center: Genesis ElderCare MD Wicomico If Under 1 Year | If Under 24 Hrs. 6. Sex

Director if then "neturel", or items 23s or 28s-f ehow the Medical Examiner must be notified at filed within 72 hours after . Or 1 Baltimore, Maryland 21215-0020 Hygiene.

Physician

/Medical

Examiner

Elsie

permit. Pages 1 and 2 should be file.
Department of Health and Mentel Hy
Important: if item 27 Is merked otherny injury or other treumstic event **Physician** /Medical Examiner

The law requiras that the death certificate be executed and physician a attending ò signed by d should should page 2 certificate Hospital or Attending Physicien:
 24 hours after death.
 Funeral Director: After this certifical eleipf filled in by the funeral director,

Box 68760.

P.O.

Records,

Division of Vital

9. Birthplece (State or Foreign Country) Maryland 8. Date of Birth (Month, Dey, Year) 08/14/1909 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 2 F Yrs. 89 215-16-7020 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits 14 Yes 2 No Salisbury Maryland Wicomico Director 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? USA 21804 200 Civic Avenue Funeral 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Housewife Own Home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be MARY RIGGIN EDWARD DENSTON 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) SHELDON PUSEY?SON 30568 CREEK VIEW DRIVE, PRINCESS ANNE, MD. 21853 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SPRINGHILL MEMORY GARDENS 3/8/99 HEBRON, MARYLAND Impeture of Funeral Service Licenses 22. Name end Address of Fecility HINMAN FUNERAL HOME 11673 SOMERSET AVE. CHMM00295 PRINCESS ANNE, MD 21853 23. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on eech line. Approximate tntervel Between Onset end Death Immediate Cause (Finel disease or condition resulting in death) zend co Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ermany a Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown by 24b. Were autopsy findings aveilable prior to completion of cause of deeth? Completed 24a. Was en eutopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medicat 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Certification: To 27. Manner of Beath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Cartifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 30. Neme end address of person who comple eted cause of death (Item 23a) (Type, Print) illiam Salisbury MDa1804 M.D. Robins, vay Dr 31. Dete filed (Month, Day, Year) 32. Registrar's Signature

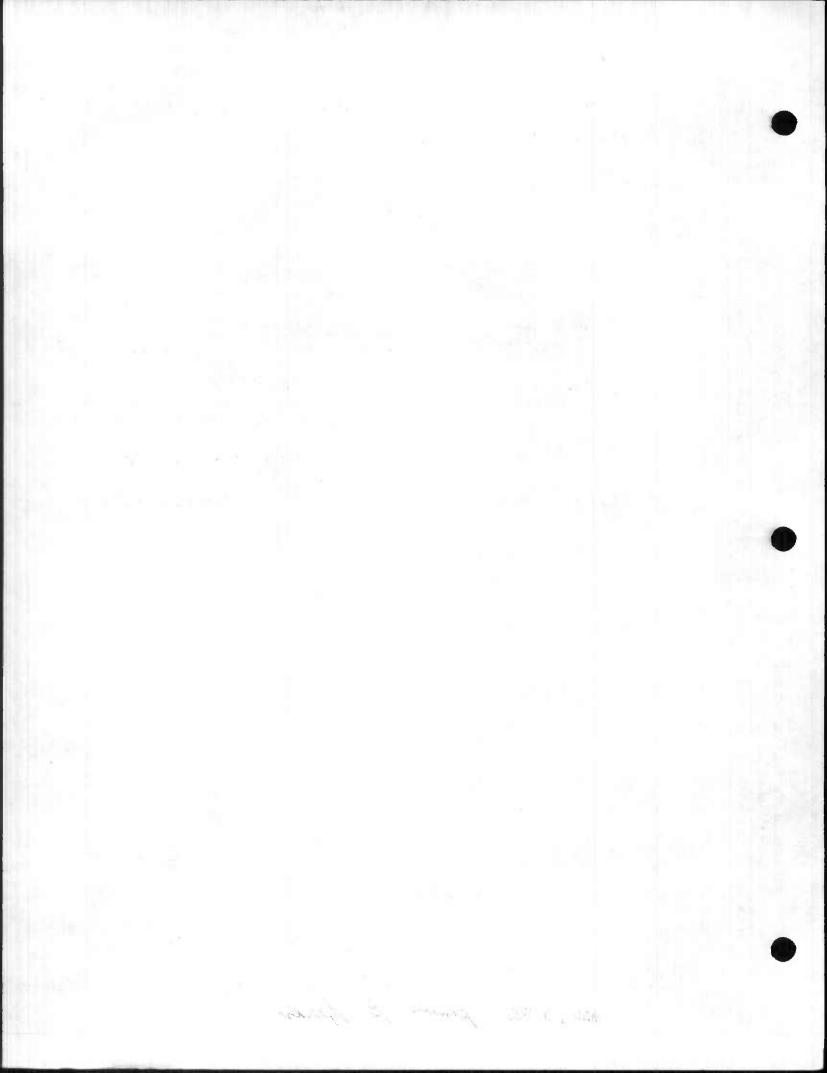
State Registrar

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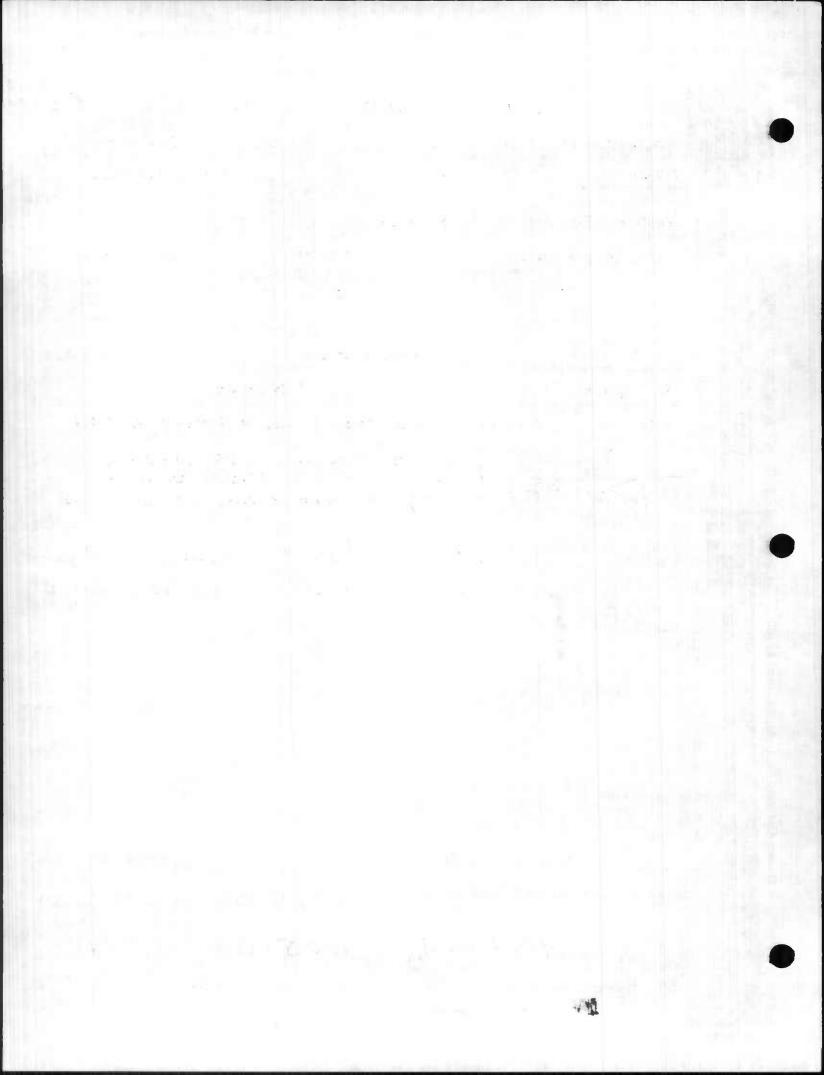
MAR 1



State of Maryland / Department of Health and Mental Hygiene

				Otato of Mar	ylaria / L	Certificate	of Death		Reg. No.	08550	
	F-4-17-1		1. Decedant's Nama (First, Middle, Last		,			2. Date of Da	ath	3. Time of Death	
	Physic /Medi		Robert Lei	roy Pa	rke	~		Febr	uary 2	5°1449 11:30PM	
	Exami		4a. Facility Nama (If not institution, give				4b. City, Town, o	r Location of Deat		of Death	
			41 West "I" St	reet			Brunsw	rick	Fred	lerick	
	Funeral Director		229-30-1/31	TIM OF	In yrs. last bir 67	thday) If Under 1 \ Months D	Year If Undar 24 Hr Beys Hours Mir	s. 8. Data of Bir	th by, Year)	9. Birthplaca (State or Foreign Country) Virginja	
15	pue M		Usual Rasidance of Decedenf 10a. State 10b. County	10	Oc City Tow	n or Location				10d. Insida City Limits	
	eho	č								1 Yes 2 No	
	the N	Director	Md. Frederi	СК	Brun	SWick 10f. Zip Co	42		10g. Citizen of V		
	with an or	Ö	41 West "I" St	root						•	
	leeth 22	era		12. Was Decedant Eva	ır in U.S.	217		Specify Yes or No	USA 14. Race	e - Amaricen Indian,	
21215-0020	d 2 should be filed within 72 hours effer deeth with the Meryland th and Mental Hygiene. The marked other than "natural", or items 23s or 28s-f show traumatic event, its Medical Evantine must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 X Divorced	Armed Forcas? 1 □ Yas 2 □ No If Yes, Giva Yaar or Datas:	orean	4 🗆 Vaa a 🗅	of Hispanic Origin? (Cuban, Maxican, Pue No <i>Specify:</i>	rto Rican, atc.)	Specify	k, Whita, afc. Black	
5-0	72 ho	Completed	15. Decedani's Edu (Spacify only highest grad	cellon	16a.	Decedent's Usual C	ccupation lona during most of w	orkina	16b. Kind of Bu	usinass/Industry	
121	within iene. than	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)			lona during most of we etired)				
12	Hygie ther ther ther ther the	ပိ	1 0			Farmer	40 44-11-14-14		Farmi		
Maryland	od of	Be	Noah Haskins					ame (First, Middle			
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Baltimore,	artmen ortant: Injury		4 Donation 5 Other (Specify)		наде	rstown C				stown, MD	
Ba	permit. Pages 'Department of F Important: If the any Injury or of		21. Signatura of Funeral Sarvica Licens	Willia	na		ddrass of Facility J Brunswi	ohn T. ck, MD	Willia 21716	ms Funeral	
		2	23a. Part1. Enlar the disease, or compl shock, or heart failure. List only or	ications that causad the	a daath. Do	nol antar lha moda o	f dying, such as cerdi	ac or respiratory a	rresi,	Approximata Intarval Batween	
N.	Physician									Onset and Death	
	/Medical Examiner		Immediata Causa (Final disease or condition	. A.S.	C.V	. D				Vears	
4	Examine		rasulting in deeth)	Du	e to (or as a	consequance of):					
	pa ti	ine		Alco	nolis	m				Years Years.	
	and I-tren	Examiner									
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the bunel-trensit										
	ding ph	Physician/Medical									
Box	eath cert attendin	clar									
0	by the stached	ıysi	Part II. Other significant conditions cor	itributing to death but n	ot rasulting in	n tha undarlying ceus	e givan in Part I.			ntributa to the cause of death?	
Φ.	es thet igned b							1/2	res 2□ No	3 Probably 4 Unknown	
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on	ding f h. After funer	tion	1 Natural 5 Pending	(Month, Day Ye		njury M	Injury at Work? 1 Yes 2 No	200. Daggribo	now injury coodin		
Division	Attending ir deeth. actor: After by the fune	fica	3 ☐ Suicida 6 ☐ Could not be	28a. Placa of Injury	- At home, fa			28f. Location (Straat and Numb	er or Rural Route Number,	
Ö	or Attend effer deeth Director: / d in by the	Certification:	4 ☐ Homicida datamined	building, atc. (5	Specify)	,,,		City or To			
	To the Hospital or Attend within 24 hours efter deet To the Funeral Director: completely filled in by the	edicai C	29a. Cartifiar 1 Certifying Phys	sician: To the best of m nar: On tha basis of exa and menner stated	amination an	, deeth occurred at t d/or Investigation, in	na tima, date and plac my opinion, death occ	ce, and dua to tha	ceusa(s) and ma date and placa, a	nnar as steted. and due to tha cause(s)	
	o the	Me	29b. Signatura and titla of certifiar			29c. Li	cense number		29d. Date signed	d (Month, Day, Year)	
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			30 Name and address of		- CC :	(Turno Paian)	00010	1	111001	212	
			30. Nema and addrass of person who co	mplated ceusa of death	h (tem 23e)	(Type, Print)	a. Pari	ck St.	Freder	11,1999 ick MD 21703	
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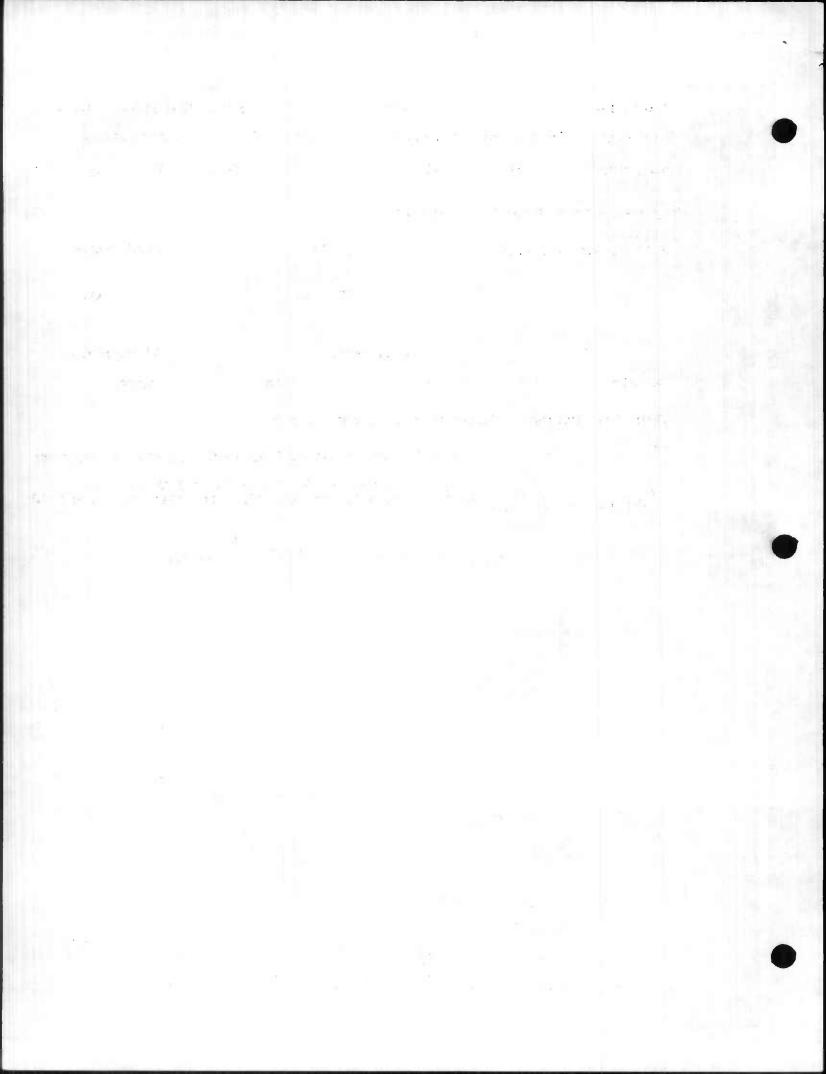
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ysician Medical		REYNOLDS	PARI			March	2, 1999		8:50 P	
niner al				If Under 1 Year Months Days	Frederi	s. 8. Data of Bir (Month, De	Freder	9. Birthpl	lace (State or Foreign try) C	
	Usual Residence of Decedent 10a, State 10b, County		ty, Town or Loc	ation					Od. Inside City Limits	
lor	Maryland Frede		rederic						1 Vas 2 No	
Funeral Director	10e. Street end Number	occi i	ceae occi	10f. Zip Coda		10g. Citizen of What Country?				
9	200 East 16th S.	treet		21701	701		United	Sta	tes	
2	11. Marital Status 1 □ Never Marriad 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 12 No if Yes, Give Yaar or Dates:		as Decedent of H Yes, specify Cub	Hispanic Origin? (ean, Mexican, Pue Specify:	Specify Yas or No into Rican, etc.)	- 14. Race Bleck	ace - American Indian, leck, White, atc.		
sted	15. Decedent's I (Specify only highest g	Education	16e. Decede	nt's Usual Occup	pation during most of w	orkina	16b. Kind of Bu	siness/Ind	lustry	
mpf	Elementary/Secondery (0-12)	College (1-4or 5+)	life. D	O NOT use retire	od)					
ပ္ပ	1 Z 17. Fathar's Neme (First, Middle, Las	18. Mother's N	ame (First, Middle,	Maiden Sumem		tore				
o Be	Ira Reynolds		Etta H							
-	19a. Informent's Name/Relationship	(Type, Print)	19b. Malling	Addrass (Street		Rurel Route Numb	er, City or Town,	Stete, Zip	Code)	
	Paula Long /	daughter				Gaithers	burg, MI	20	878	
	20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3	20b. I	Place of Dispos cemetery, crem	tion (Neme of story or other ple	ice)	Dete	20c. Location -	City or To	wn, State	
	4 □ Donetion 5 □ Other (Spec	ify) Ha	gerstow	n Cremat	tory	3/3/99	Hagersto	own,	Maryland	
	21. Cignature of Funeral Service Lice	ensee	22.	Name and Addre	ess of Facility	Stauffer	Funeral	Home		
Popular Examiner 23 Security and Indicate an	23a. Part . Enter the disease, or co- shock, or heart fellure. List onl Immadiate Ceuse (Final disease or condition resulting in deeth)	. Conge		the mode of dyi		Pike, Frac or respiretory e			Approximete Interval Between Onset and Death	
nine		10. Cerul	nli	rai c	elas C	recid	ents	2	yrs	
edical Exar	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that Initiated avents resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of):									
Physician/M	Part II. Other significant conditions	dcontributing to death but not res	sulting In the une	derlying cause gi	ven in Pert I.	23b. Dfd tobacco use contribute to the cause of dea				
by Pt						- 10	Yee 2□ No	3 Prot	pably 4,—Unknown	
Completed t							en eutopsy ormed?	ava	ere eutopsy findings ailable prior to mplation of causa death?	
Con						10	Yas 28 No	10	Yes 2 No	
Be	25. Was case referred to medical examiner?					eath (Check only	one)			
2	1□ Yes 2⊡ No		ER/Outpatient	3LI DUA		Home 5 ☐ Resi			y)	
cation:	27. Manner of Death 1 Neturel 5 Pending investigeti		28b. Time of Injury	28c. fnju Wo M 1 □	ny et ork?] Yes 2 □ No	28d. Describe	how injury occurr	ed		
Certification:	3 Suicida 6 Could not determine	28e. Plece of Injury - At h building, etc. (Speci	ome, farm, stre	et, factory, office		28f. Location (City or To	Street and Numb wn, Steta)	er or Rura	i Routa Number,	
edical	29a. Certifier (Check only one) 1 ☐ Certifying P 2 ☐ Medical Extra	hysician: To the best of my knominer: On the basis of exemine and manner stated.	owledge, death etion end/or inve	occurred at the ti estigetion, in my	ime, date end ple opinion, deeth oc	ce, end due to the curred at the time,	cause(s) and me date and place, a	nner es st and due to	tated. the cause(s)	
M	29b. Signature end title of certifier	of Hun	1)	29c. Licen	se number	11	29d. Date signed	(Month,	Day, Year)	
tate	30. Name and eddress of person who Robert S 31. Date fillad (Month, Deckler)	completed cause of deeth liter Aughes 7 32. Regisfrate Sign.	00 Mo	11 -	e Ave	2, Frea	brick,	MD	21701	



State of Maryland / Department of Health and Mental Hygiene Q

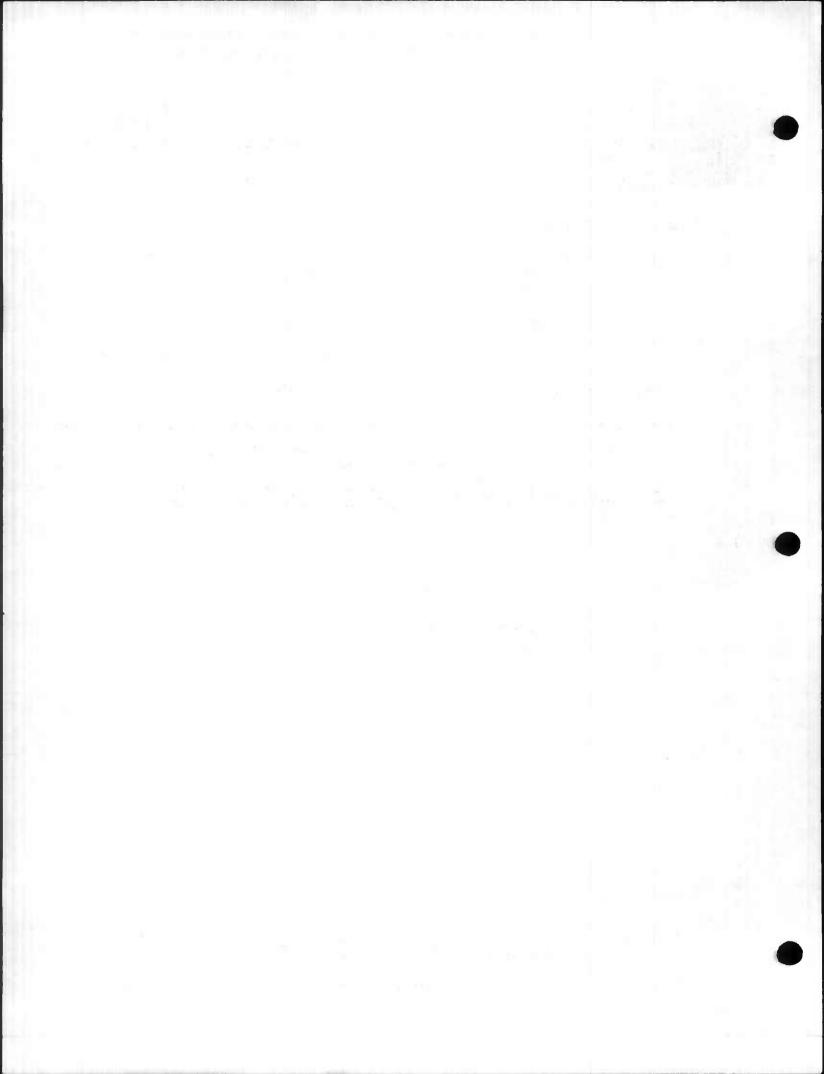
Certificate of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death 2. Dete of Death Day **Physician** 20, Giovanna 6:20P. Russo Feb. 1999 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Undar 1 Yaar | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) Feb. 7, 1907 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthpleca (State or Foreign **Funeral** Days Hours Min 1□M XXF Italy 92 217-42-8759 Yrs. **Director** Usuel Residence of Decedent permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Intropretant: If Item 27 is marked other than "naturel; or items 23a or 28a-1 show eny injury or other traumatic event, the Medical Eventman. 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits Prince George's Maryland Adelphi 1 Yas 2 No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 3317 Powder Mill Road 20705 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes XX No if Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Ricen, etc.) Race - American Indian, Black, Whita, atc. 11. Marital Status 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dress maker self employed 17. Fathar's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumema) Be Carmelo Russo Pao1a Caruso 2 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) A.Lauretta Calabro (daughter in law) same as #10 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBuriel 2 Cramation 3 Removal from Stata Fort Lincoln Cemetery 2/23/1999 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complication 1, at ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuter on each line. Approximate Intervel Between Onset and Deeth **Physician** Immediate Ceuse (Final diseese or condition resulting in deeth) /Medical a ARTHUSCURETI Examiner Due to (or es e consequence of): Examiner physician and s tha buriai-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immadiate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): SB usa signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Ď 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes en autopsy performed? Completed s cartificate has b director, page 2 s 2800 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was cese referred to medicel exeminer? funaral director, Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 npatient 2 ER/Outpatient 3 DOA Aftar this 28e. Date of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Natural 5 Pending invastigation death. 1 ☐ Yes 2 ☐ No 2 Accident n 24 hours after death

• Funeral Director: /
blataly filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 4 | Homicide 29a. Certifier Certifying Physician; To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. edicai complataly 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end, manner stated. (Check only one) To the F Within 2 29d. Data signad (Month, Day, Year) 29b. Signature end title of certifian 29c. License number 20391 23a) (Type, Print) 30. Neme and eddress of person with ompleted cause of death (Item BELCREST RD SUPTOVILLE MO 20782 DR. JEFFREY 4525 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State MAR 0/2 1999 Registrar



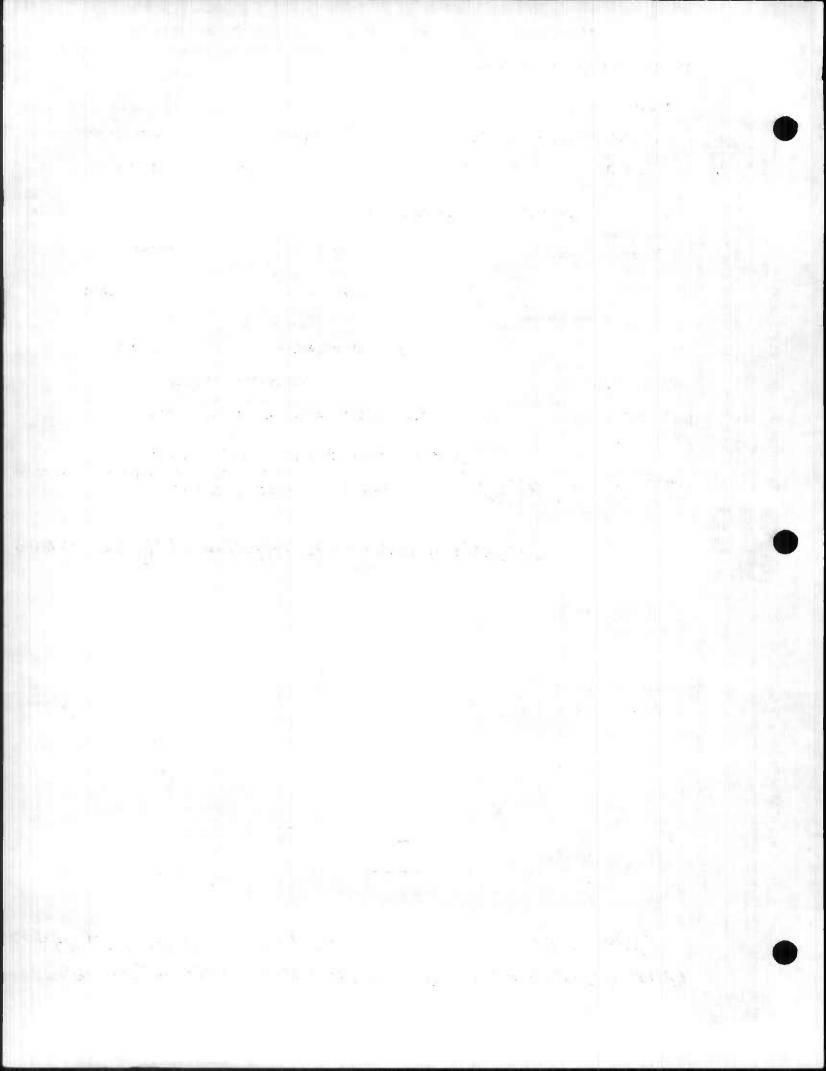
				State	of Marylan	d / Depa <i>Cei</i>	artment of rtificate o	Health of Death	and N	Mental Hyg	jiene 9 (9 0	85	53
	Dhamini		1. Decedent's Nama (First, Middle, La	st)						2. Dete of Dee Month	th Day	Yeer	3. Tim	ne of Deeth
	Physici /Medi		Kanta Rawat							Februar			6	:54 AM
	Examir		4a. Facility Neme (If not institution, given	e street and nu	mber)			4b. City, To	own, or L	ocation of Death	4c. County	of Deeth		
Ĺ			Shady Grove Ad	ventis	t Hosp	ital				le MD	Mon	tgon	nery	× 1
	Funeral		5. Social Security Number 6. S	Sex □M 2XIF	7. Age (In yrs.		If Under 1 Ye Months Da		Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	olece (State)	ata or Foreign
es.	Director		456-45-0217	LOW ZWY	68	Yrs.				November			dia_	
	and and		Usuel Residence of Decedent 10a. Stete 10b. County		10c. Cit	y, Town or Lo	cation					1	Od Insid	le City Limits
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	288 Inoutif	Directo	Maryland Montgo	mery		Gaithe	ersburg	e		On Citizen of	g. Citizen of What Country?			
	3a or		1141 Knollmist I	am 6			208				India			
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiane. Is marked other than "natural", or items 23a or 28=f show aumatic event, the Medical Examiner must be indiffed at	Funeral	11.41 KIIOIIIIIISL 1	12. Wes Dec	adent Ever in U,	S. 13. V			rlgin? (Sp	ecify Yes or No- Rican, etc.)		e - Americ	an India	n,
0	r the		1 ☐ Never Married 2 ☐ Married	Armed F	2 X No					Rican, etc.)	Ble	ck, White,	etc.	
0	al', o	by	3 Nidowed 4 □ Divorced	if Yes, G Yeer or D	ve Dates:	I□Yes 2ሺNo Specify:				Specify: Asian Indian			dian	
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and and	d in b		17. Fether's Name (First, Middle, Last)				18. Moth	er's Nem	e (First, Middle, i	Maiden Suman	ne)		
aryland	should be ind Mental markad or umatic eve	2	Nanae Singh Har						are		ot avai			
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e,	is 1 and 2 should of Health and Men item 27 is marka other traumatic		Deepak Rawat / sc 20e. Mathod of Disposition	n	20h P	11054	Grassy	Knoll	Ter	race, Ge	20c. Location			20876
Ö	Pages nent of I int: If its iry or o		1 ☐ Burial 2 🖾 Cremation 3 ☐				sition (Name of natory or other				20C. Location	- City of 10	WII, Stat	0
altimore,	it. Pr		4 Donetion 5 Other (Special		^		y Crema		-	c. I	Bethesd	a, Ma	ryla	and
Ba	permit. Pages Department of Important: If it any injury or o		21. Signeture of Funeral Service Licer	2 10 :	M008		Nama and Ad bert A. F			al Home/	Bethesda.	-Chevy	Chas	se, Inc.
			23a. Pert1. Enter the season or com shock, or heart failura. List only	juccin o	Mr. Maria					Bethesda,		2081	4-350	01
	Physician /Medical Examiner phasician and physician and physician and the prival-transit	Examiner	Immediate Cause (Final disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or injury	b. Acut	Due to (o	res e conseq erdial res e conseq	uence of): Infarct uenca of):	ion						
BOX 68/60,	ath certific ttanding p or use as	Physician/Medical	Ceuse (Diseesa or injury thet initiated avants resulting in daath) Lest	d	Due to (or	resaconsequ								
o.	ras that the da signed by the a I be detached f	ysic	Part ii. Other eignificent conditions of	ontributing to d	eath but not resu	ulting in the ur	ndarlying cause	given in Pert	I.	23b. Did to	obacco use co	ntribute to	the cau	use of death?
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ecords,	law requiras las been sign s 2 should be	Completed by								24a. Wes e perfor		ev	elleble pi	osy findings rior to of cause
Ĭ	The law	Con								1 🗆 Y	es 2X No	10	Yes	2□ No
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0	Physician: this certific ral director,	7	1⊠ Yas 2□ No		-	ER/Outpetien	T 3LI DOA		ursing Ho	me 5 ☐ Reside	ence 6 Oth	ner (Specif	y)	
ב	ding P. Aftar funer	ino.	27. Manner of Deeth 1 ☑ Natural 5 ☐ Panding		of Injury th, Day Year)	28b. Time of injury	\ \	njury at Vork?		28d. Describe h	ow injury occur	rred		
<u>s</u>	tending leath. death. tor: Aftar the fune	cat	2 ☐ Accident invastigation 3 ☐ Suicide 6 ☐ Could not b					☐ Yes 2☐						
UNISION	of or Attending F safter death. I Director: After In by the funer	Certification:	4 ☐ Homicide determinad	28e. Piece	of injury - At ho ing, atc. <i>(Specif</i>)	ma, farm, stre	eet, factory, offi	ca		28f. Location (Si City or Town	treat and Numi n, Stata)	ber or Hura	Il Houte	Num <i>ber</i> ,
	ours ours oral filled		29a. Cartifiar 1 Certifying Ph	velcien: To the	hast of my know	wladaa daath	a course of at the	. timo . data			a/-\ d			
	P Hose	edicai	(Check only 2 Medical Examone)	ilnar: On tha b	asis of axeminat nar stated.	ion end/or Inv	estigetion, in m	y opinion, dec	eth occuri	ed at tha tima, d	ata and plece,	end dua to	the cau	se(s)
	To the Hospital of within 24 hours a To the Funeral D complately filled in the Funeral D complately filled in the formula of the Hospital of t	Me	29b. Signeture end title of cartifier	0	-		29c. Lice	ense number		2	9d. Date signe	d (Month,	Day, Ye	ar)
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	2		30. Name end porress of person who	caus	sa of daath (Item	23e) (Type, I		, 0	,		Februar	y 21	, 19	フブ
			Eugene Spagnuolo,					Drive.	Roc	kville.	Marv1a	ind :	2085	0
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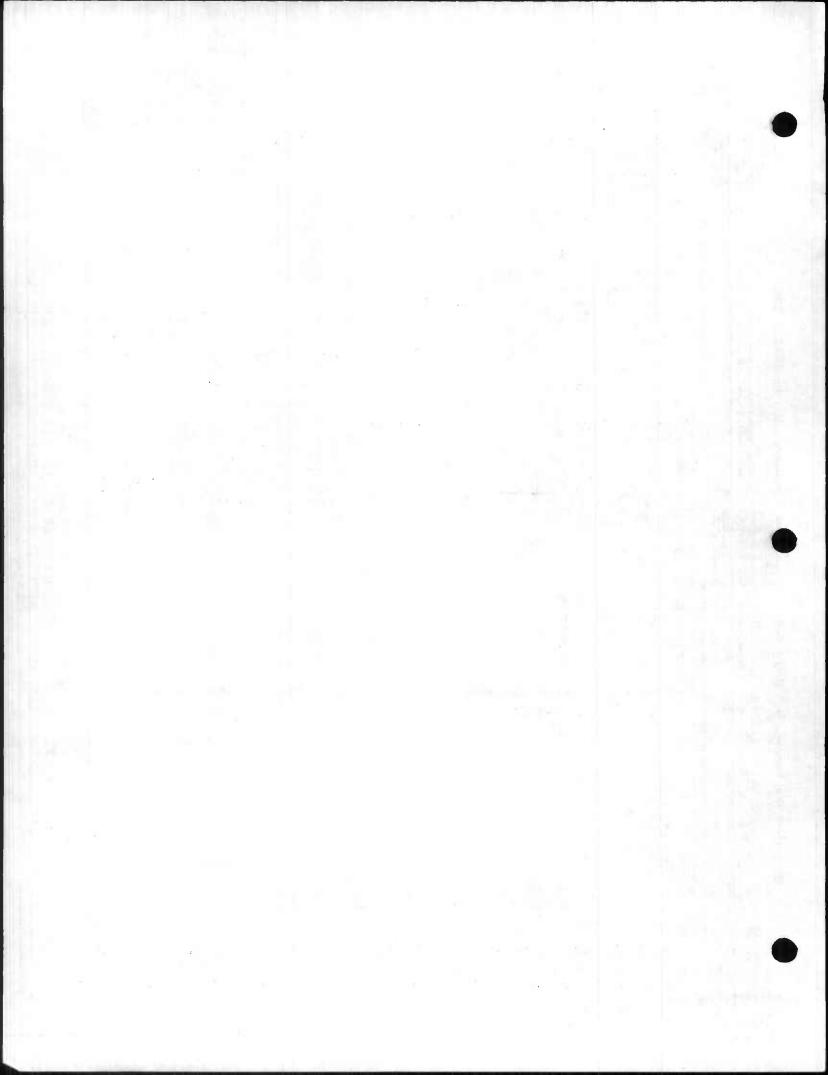
State of Maryland / Department of Health and Mental Hygiene ()

Item: 19a per Informant G-769 3/23/99 reb Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vesi **Physician** LUCIE 27, 1999 4c. County of Death :37 FUBRUARY · /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MONTGOMERY WASHINGTON ADVENTIST HOSPITAL OLNEY Hours Min. 8. Data of Birth (Month, Day, Year) 4. AUGUST 6, 1925 HAITI If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days 1□M 2\ F Months 579-64-6005 Director Usual Rasidance of Decedani the Manyland 10a. State 10d. Insida City Limits 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No MONTGOMERY TAKOMA PARK MD Directo 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? with 20912 HATTT 7128 CARROLL AVE. Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after-Hygiene. 1 ☐ Yes 2 No If Yes, Give Yaar or Dates: 1 ☐ Never Married 2 ☐ Married Specify: BLACK Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) 11 DAY CARE PROVIDER DAY CARE 7 is marked other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumama) Be Peges 1 and 2 should be nent of Health and Mentel out: If Item 27 is marked or THERANCIA ETIENNE DUPERON RENE 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GUY RENE (SPOUSE) 7128 CARROLL AVE. TAKOMA PARK, 20912 [son] other Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 0 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department of Important: If any injury or pace. 3-6-99 BRENTWOOD, MD 4 ☐ Donation 5 ☐ Other (Specify) FORT LINCOLN CREMATORY of Foueral Service Licenses 22. Name and Address of Facility HINES-RINALDI 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Acute Inferior wall Myocardial Marcha /Medical Immediata Causa (Final 2 Hours diseasa or condition resulting in death) **Examiner** Examiner sician and buriel-trans Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or as a consequence of): requires that the death certificate be execu physician s the buriel Box 68760. Physician/Medicai Due to (or as a consequence of): 98 USB 0 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Unknown 1 Yes 2 No 3 Probably pe Records. þ Sign De 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? page 2 1 ☐ Yes 2 ☐ No 1 Yes certificate Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica director, 25. Was case referred to medical Be 26. Place of Death (Check only one) axaminer Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Lo 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicida 24 hours 6 • Funeral I Medicai 29a. Certifier Certifying Physician: To the best of my knowledga, daath occurrad at tha time, date and placa, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certify 29c. License number 294. Date signed (Month, Day, Year) sa ot death (Item 23a) (Type, Print) M.D. 12016 GEORGIA AVENUE WHEATON MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 03 Registrar



State of Maryland / Department of Health and Mental Hygiene 0 0 0 5555

				Certifica	te of	Death		Ĭ	Reg. No.	2 0	0.0	JU
4140.4	1. Decedent's Neme (First, Middle,	Last)						2. Dete of De Month	eath Dev	Year	3. Time	of Death
Physician /Medical	Henry Milton	Riti	nour						2, 1999		8:45	5 PM
Examiner	4a Facility Name (If not institution,	give street and number)				4b. City, To		cation of Deat		y of Death		
	Manor Care Chevy	Chase				Chevy	Chas	e	Mont	gomer	у	
Funeral Director	579-01-4711	3. Sex 7. Age (in 152 M 2□ F 84	yrs. last birtl Y	nday) If Under	er 1 Year Deys			8. Dete of Bir (Month, De January	th ey, Year) 18, 1915		olace (Stei ntry) gini	e or Foreign a
anyland ahow date	Usual Residence of Decedent 10a. State 10b. County Montrol		City, Town			-				1		City Limits
oto de Maria	Maryland Montgon	lery	etheso									es 2 🔀 No
th with the Ma 23s or 28s-f a sat be notified al Director	10e. Street and Number 6003 Madawaska I	Road		10f. Z	ip Code 208	16			10g. Citizen of			
within 72 hours after death with the Maryland ons. Than "retures", or hems 23s or 28s-f show he Medical Examiner must be notified at ompleted by Funeral Director	11. Marital Status 1 ☐ Never Merried 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever Armed Forces? 1 X Yes 2 No V If Yes, Give Year or Detes: Wat	Vorld			Hispanic Or ban, Mexica Specify		cify Yes or No Rican, etc.)	Speci	ice - Americ eck, White, ity:		
"netural",	15. Decedent's		16a. I	Decedent's Us	uel Occu	pation			16b. Kind of 8	Business/In	dustry	
ed within 72 ho ygiene. er than "naturn it, me wedeall	(Specify only highest Elementary/Secondary (0-12) 1 2	College (1-4or 5+)		(Give kind of w life. DO NOT strict				ng		otive		
# I & I	17. Father's Neme (First, Middle, L	ast)	1 2 2 1					(First, Middle	, Meiden Sume			
Mentel H Mentel H arked out aftic aver To Be	George Ritno	our				F10	rence	Maria	n Ander	son		
and Ment and Ment aumatic aumatic	19a. Informent's Neme/Reletionshi	p (Type, Print)	19b.	Meiling Addres	ss (Stree	t end Numb	er or Rura	I Route Numb	er, City or Town	n, Stete, Ziu	Code)	
D = 7 = 2	Anne M. Shannon/								ngs, Il			550
-155	20a. Method of Disposition	20	b. Piece of	Disposition (No. cremetory or	eme of	au, we	ESCEI	Dete	20c. Location			
parmit. Pages Department of I Important: if its any injury or o pitca.	1 ☑ Burial 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (Sp. 21. Separature of Funerel Sérvice L	ecity) (f Heave	en Co	emeter	ry ! ityRobe	ert A.	Silver Pumphre	y Fur	neral	Home/
40E48	1	the moon			Bet	hesda	, Mar	yland	7557 W 20814-3			
Physician	23a. Fartt Etter the diseese, or connect or main tallure. List o	omplications that caused the only one cause on each line.	deeth. Do n	ot enter the mo	ode or dy	ing, such es	s cardiac o	r respiretory a	irrest,	1	Approxir Intervel I Onset er	Between
/Medical Examiner	Immediate Cause (Finel disease or condition	Lung C	ancer							2	year	rs
127.0	resulting in death)	Due	to (or as e c	onsequence of):							
icate be executed physician and s the burial-transit edical Examiner	Sequentially list conditions,	b	Due to (or es e consequence of):									
ilclan s burial	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events	c										
00	resulting in death) Last	Due (o (or es e co	r es e consequence of):								
d for use	Part II. Other significant condition	a contribution to doubt but and	san dina la	the contest in a		han in Bod		225 DId	tehana una a	amedia da é	a tha anu	on of death?
d by the attendir letached for use Physician/N	Abdominal Wall	resulting in	the underlying	cause g	iven in Peri	1.		tobacco use c Yes 2□ No				
page 2 should be detach									s en eutopsy ormed?	6/	ere eutop vailable pri ompletion death?	sy findings or to of cause
page 2 s								10	Yes 2⊠No	1	□Yes 2	2□ No
certificata rector, pa	25. Was case referred to medical					26 Dies	a of Death	(Check only				
	examiner?	Hospitel:	2 EB/O-	patient 3 C	004	hor:			idence 6 🗆 O	ther /Coor	tv1	
rithis oral of	27. Manner of Death	28a. Dete of Injury (Month, Dey Yes		me of	28c. Inju		-		how injury occu		97	
eath. for: After the funer cation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investige		r) In	jury M		ork?]Yes 2⊡]No					
within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral Medical Certification:	3 Suicide 6 Could no 4 Homicide determin		At home, fen	m, street, facto	ory, office				(Street and Num wn, Stete)	nber or Rur	al Route N	lumber,
n 24 houn n 24 houn ne Funere pletely fille	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best of my carniner: On the basis of exar and menner steted.	knowledge, ninetion end	deeth occurred for investigation	d et the t	ime, date er opinion, de	nd place, e eth occurre	end due to the ed et the time,	cause(s) end n date end place	nenner es s , end due t	stated. o the caus	e(s)
Within Youth	29b. Signature and title of certifier	.1 0		2	9c. Licen	se number			29d. Date sign	ed (Month,	Day, Yea	r)
1041	* Klein	3. Walen	M	.D.		D2312	7		March 4	, 199	9	
,	30. Name and address of person w Kevin G. Nealon				enue	#92	5 Che	vv Cha	se, Mar	vland	2081	5
State Registrar	31. Date filed (Month, Day, Year)	32. Pegistrer's S	Charles and a second	, ,	a K		0116	· J Olla	oc, nai	<i>j</i> Land	200	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth Month OZ ROBLES DIMAS 13:00 H 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Suburban Hospital Bethesda Montgomery Hours Min. 8. Date of Birth (Month, Dey, Yea March 25, If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) Deys Year) Months 1 1 M 2 □ F 579-11-3611 43 1955 Peru Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2X No Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2500 Kimberly Street 20902 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Yeer or Dates: 1₺Yes 2□No Specify:Peruvian Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Automotive 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Basilia Chamorro Felix Robles 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 2500 Kimberly St., Silver Spring, MD 20902 Nelly Robles/Wife 20b. Plece of Disposition (Neme of cametery, cremetory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Gate of Heaven Cemetery 3/1/99 4 ☐ Donetion 5 ☐ Other (Specify) Silver Spring, MD 22. Name end Address of Fecility Francis J. Collins Funeral 21. Signeture of Funeral Servica Licensee Home, Inc. 500 University Blvd., West Silver Spring, MD 20901 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. ACUTE MYOCARDIAL INFARCT Immediete Ceuse (Finel diseese or condition resulting in deeth) HOURS Due to (or es e consequence of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury Due to (or es e consequence of) thet initieted events resulting in deeth) Lest Due to (or es e consequence of) Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uee contribute to the cause of death? Patricia & Tomsko MJ 1 Yes 2 No 3 Probably 4 Unknown DEHYDRATION FLU LIKE SYNDRUME 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 des 2 No 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 2 Accident

25. Wes case referred to medical exemple? 1 Nes 2 No

27. Menner of Deeth 1 Neturel

3 ☐ Suicide

4 Homicide

5 Pending investigation 6 Could not be determined

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.
2 Medical Exeminer: On the bests of examination end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier

29c. License number D 29256

29d. Dete signed (Month, Dey, Year) FEBRUARY 26, 1999

30. Neme end edd

TOSE A. QUIRUS M.D. 4343 MONTGORERY M BETHESDA NO WSSY

Registrar

Physician

/Medical

Examiner

Funeral

Director

an "natural", or items 23s or 28s-f show Medical Examiner must be notified at

1 and 2 should be filed within 72 hours efter Health and Mental Hygiene.

permit. Peges 1 and 2 st Department of Health and Important: If Item 27 is n any injury or other traun

Physician

/Medical

Examiner

nding physician and use as the burial-transit

Examiner

Physician/Medical

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Completed

Be

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death.

To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the f

Certification: To

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Baltimore, Maryland 21215-0020

Director

Funeral

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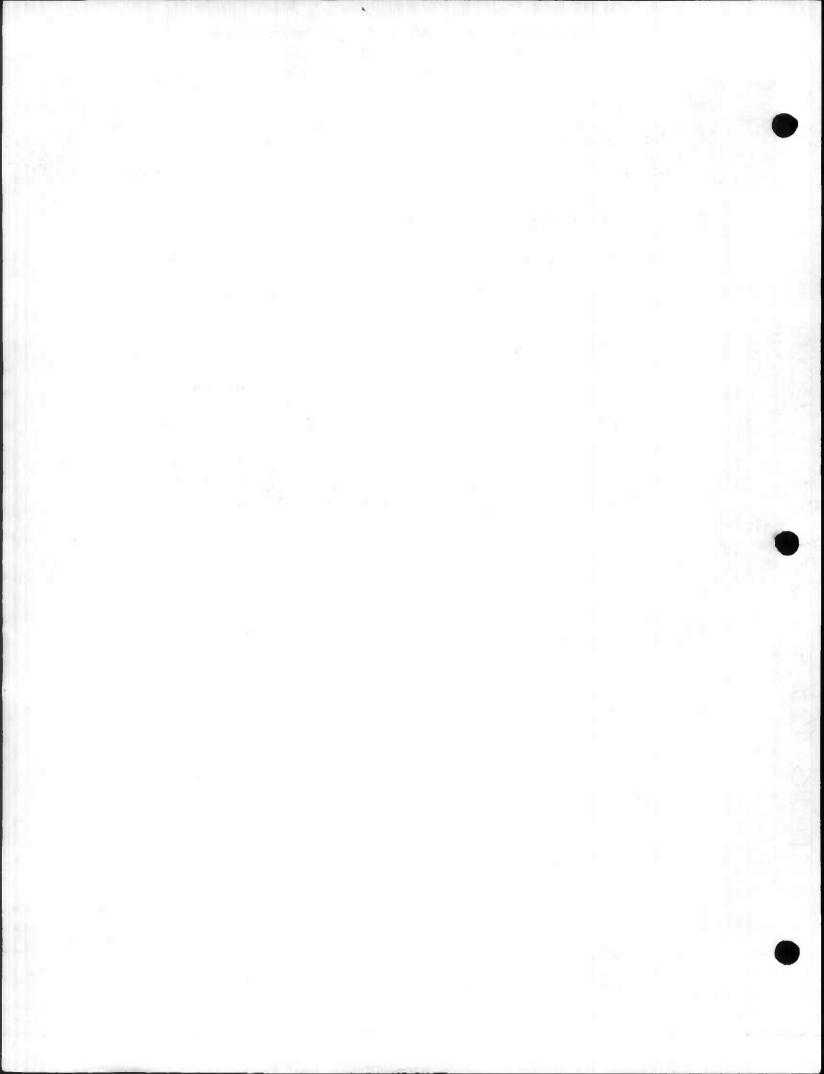
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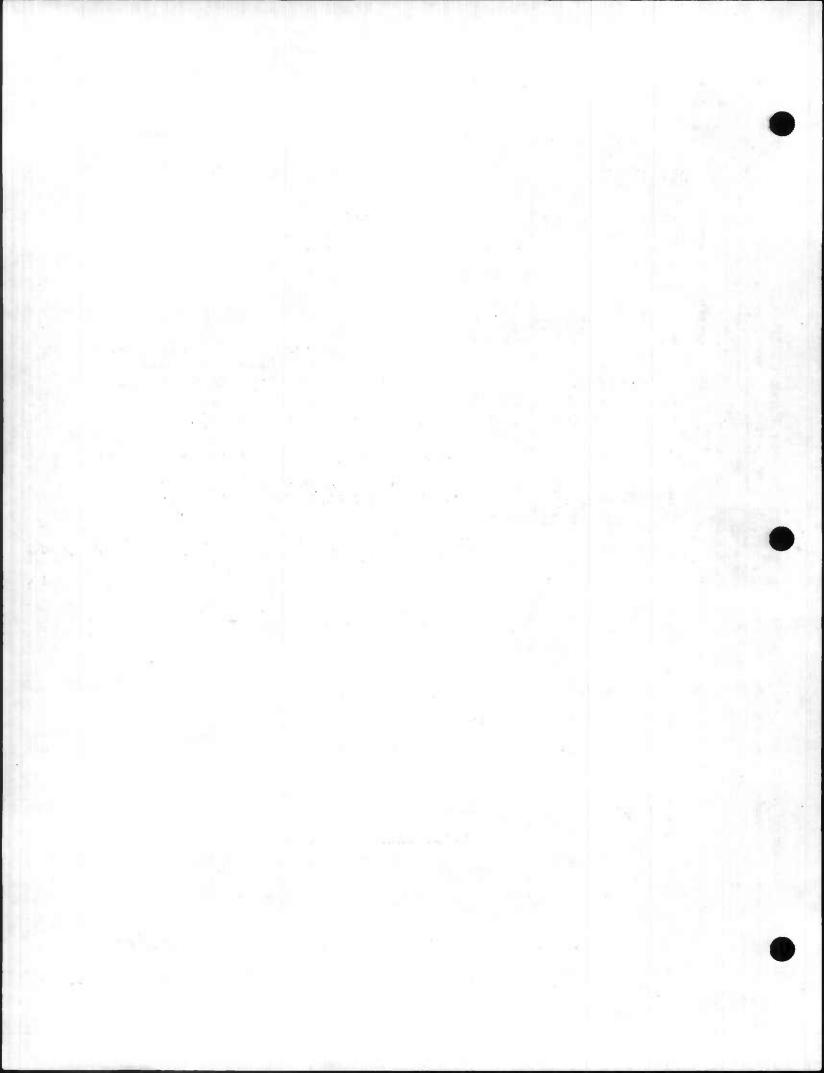
31. Dete filed (Month, Day, Year) MAR 02 1999 32. Begistrar's Signeture

28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify)



State of Maryland / Department of Health and Mental Hygiene 9 0 85

	1. Decedent's Name (First, Middle, Las	ef)		ertificate of	Dour	2. Date of De	Reg. No.	3. Time of Death		
Physician	JOHN		CC			Month FEB	Day 19	ar .		
/Medical	4a Facility Name (If not institution, give		55		4h City Town o	or Location of Deat				
Examiner			+-1		Laure			e Georges		
	Laurel Regio 5. Social Security Number 6. S.		Tall In yrs. last birthde	If Under 1 Year				Birthplace (State or Foreign		
uneral Pirector			3 2 Yrs.	Months Davs	Hours M	in. (Month, Da Mar.	22,1916	Maryland		
å m	10a. State 10b. County	1	0c. City, Town or	Location				10d. Inside City Limits		
in in	MD Howar	rd br		olumbia				1 ☑Yes 2 ☐ No		
or 28e-f si be notified Director	10e. Street and Number			10f. Zip Code		T	10g. Citizen of What	Country?		
0 0	5502 Waterlo	oo Road			045		U.S.A			
r Herna 23a or 28a-f show siner must be notified at Suneral Director	11. Marital Status	12. Was Decedent Eve	er in U.S. 1	3. Was Decedent of h		(Specify Yes or No		merican Indian,		
by F	1 Never Married XXMarried 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 No		erto Rican, etc.)	Specify: B			
ted fat	15. Decedent's Ed	ucation	16a. De	cedent's Usual Occup	pation	m d in a	16b. Kind of Busine	ss/Industry		
or than "natural,	(Specify only highest gra- Elementary/Secondary (0-12)	College (1-4or 5+)	life	ve kind of work done DO NOT use retire	d)	rorking				
E O	8th	Conlege (1 451 51)		Park Ser	vices		U.S. Go	vernment		
Be C	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle	, Maiden Surname)			
To B	Reason Ross				Sa	rah Lou	ise Matt	hews		
traumatic event,	19a. Informant's Name/Relationship (7	Type, Print)	19b. Ma	ailing Address (Street	and Number or	Rural Route Numb	er, City or Town, Stat	e, Zip Code)		
tra	Rena Ross (Dau	ighter)	885	4 Cherry	Lane,	Laurel	, MD 207	08		
othe	20a. Method of Disposition			sposition (Name of rematory or other pla	•	Date	20c. Location - City			
70	XXBurial 2 ☐ Cremation 3 ☐	Hemoval from State				2 /0 /00	Q.,,,,,	11- 10		
Injury B.	4 Donation 5 Other (Specify		Maryra	and Vet.		3/8/99	Crownsv	LITE, MD		
any injury or page.	21. Signalure of Funeral Service Licen	Show	Den	22. Name and Address SNOWDEN ROCKVIL:	FUNERA	AL HOME 20850	, P.A.			
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the	e death. Do not	enter the mode of dyi	ng, such as card	liac or respiratory a	rrest,	Approximate Interval Between		
sician edical			1	1	1			Onset and Death		
	tmmediate Cause (Final disease or condition	R	050172	tora I	Ellure	2 , .		2 week		
ner	resulting in death)	a. Du	e to (or as a cons	-	CUITA					
ě		P,	reumo					2 week		
Examiner	Sequentially list conditions	b. Du	e to (or as a con:					years		
EX	if any, leading to immediate cause. Enter Underlying	/	Inani!		const	o mono		Wester		
dicai Examir	Cause (Disease or Injury that initiated events									
100	resulting in death) Last									
for use as t		d								
C a	Dati Ottoria					1				
y Physician/M	Part II. Other significant conditions co	/ /	//		ven in Part I.		23b. Did tobacco use contributs to the cause of de			
de de	Meta	bolic ac	10051S			10	Yes 2□No 3□	Probably 4 SUnkno		
d by P		\cap	11	11		24a Was	an autopsy 24	b. Were autopsy findings		
Completed	Decve	ased me	ental:	Status	4	perfe	ormed?	available prior to completion of cause		
Compl								of death?		
S						10	Yes 2 No	1 ☐ Yes 2 ☐ No		
Be	25. Was case referred to medical examiner?				26. Place of D	Death (Check only	one)			
2	1 Yes 2 No	Hospital:	2 ER/Outpat	ient 3 DOA Ott	ner: 4 Nursing	Home 5 ☐ Resi	dence 6 Other (5	Specify)		
	27. Manper of Death	28a. Date of tnjury (Month, Day Y	ear) 28b. Time		y at	28d. Describe	how injury occurred			
atio	1 Natural 5 Pending 2 Accident Investigation		out/ Injur		Yes 2 □ No					
Certification:	3 ☐ Suicide 6 ☐ Could not be determined	280. Place of injury	- At home, farm,	street, factory, office		28f. Location (Street and Number of	Rural Route Number,		
er	4 LI HOMICIOE	building, etc. (Specify)			City or To	wn, State)			
edicai C	29a. Certifier (Check only one)	velcian: To the best of m	amination and/or	ath occurred at the til investigation, in my o	me, date and pla opinion, death oc	ice, and due to the curred at the time,	cause(s) and manne date and place, and	as stated. due to the cause(s)		
completely filled in by the fune Medical Certification		and manner stated		20c Liecas	e number		20d Data signed 44	onth Day Year		
3	29b. Signature and title of ceruller	myn,	M	29c. Licens		7	29d. Date signed (M	Onin, Day, 1881)		
	umocy 1.	Milla	1	1 93	1953	-	3/1/7	7		
	30. Name and address at person who o	ompleted cause of deat	h (Item 23a) (Typ	e, Print)	_	()	/	-		
3	Time H. P. 1	MCCIAN	771	11.00.00	(· 4 /	RUMIN	ID 20707		
	/ / FVI O FIA S / C /	1 111 110	201	PVINCE	(p) are	WI L	anieli	10 2010		
State	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	rrince	George	WI C	aure/r	D 2010,		



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Data of Daath 3. Tima of Death **Physician** March Forrest Theodore 1999 Roser 6:30 AM Sr. /Medical 4b. City, Town, or Location of Daeth 4a Facility Nama (If not institution, give street end number) 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Yeer 5. Social Sacurity Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) July 3, 19 6. Sax Birthplaca (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours 217-12-2534 76 Yrs. July Director Maryland Usual Rasidance of Decedan the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or itams 23s or 28s-f show adical Examiner must be notified at Carrol1 1 ☐ Yas 2 No Keymar Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with and of health and Mental Hygiene.

Antif item 27 is marked other than natural, or items 23s or introdent that any or other than the work, the Medical Entiring man by any or other thaumatic event, the Medical Entiring man by 21757 U.S.A. 6790 Middleburg Rd. Funeral 12. Wes Decedant Ever in U,S. Armed Forcas? 1 ☐ Yas ≥ ②No If Yas, Giva Yaar or Datas: 14. Race - American Indian, Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status Bleck, White, etc. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: by 3 Widowed 4 Divorced White Completed 15. Decedant's Education (Spacify only highast grada complated) 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT usa retired) Elementary/Secondary (0-12) College (1-4or 5+) truck driver transportation 18. Mothar's Name (First, Middle, Maiden Sumema) 17. Fathar's Neme (First, Middla, Last) Be Forrest A. Roser Nannie Lambert 19b. Melling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Keymar, MD 21757 Margaret Joanne Airing/daughter 6801 Middleburg Rd. 20b. Place of Disposition (Name of camatery, cramatery or other place)
Haugh's Cemetery 20a. Mathod ot Disposition 20c. Location - City or Town, Steta 1 XBurial 2 Cramation 3 Ramoval from Stata permit. Page Department of Important: If eny injury or once. 3/4/99 nr. Ladiesburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility Hartzler Funeral Home 21. Signature Fundlel Service Lice Ver 6 E. Broadway Union Bridge, MD 21791 23a. Part1. Enter the disease, or complications that caused per death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each remarks Approximete Intarval Batween Onset end Death **Physician** /Medical Immediata Ceusa (Final disease or condition rasulting in deeth) Examiner Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiate causa. Enter Undarlying Causa (Disaase or Injury that initioted events rasulting in daeth) Last P.O. Box 68760. Physician/Medical Dua to (or as a consequence ot): d for use as t signed by the at d be datached ic Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco was contribute to the causs of death? 1 Yss 2/SAO 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, by 24b. Ware autopsy tindings available prior to Completed 24a. Was en autopsy peen completion of causa of death? cartificata has t 1 Yes ANO 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director 25. Was casa ratarred to medical Be 26. Piaca of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: 1 Yas No Impatient 2 ER/Outpatient 3 DOA Certification: To Aftar this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Natural 5 Pending 1 Yas 2 No death. investigation 2 Accident after death Director: 3 Suicida 6 Could not be determined 28t. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At home, term, street, tectory, office building, atc. (Specify) 4 Homicida filled in 24 hours a Hospital 29e. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, deta and place, and dua to the cause(s) end manner as stated. edical within 24 hor To the Fune completaly fi (Check only one) 2 Madical Examiner: On the basis of exeminetion and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the ceusa(s) and manner stated. ŝ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 D16428 30. Nama and address of person who complated cause of death (Item 23a) (Type, Print)

300 W. 9th St

32. Registrar's Signature

Frederick, MD 21701

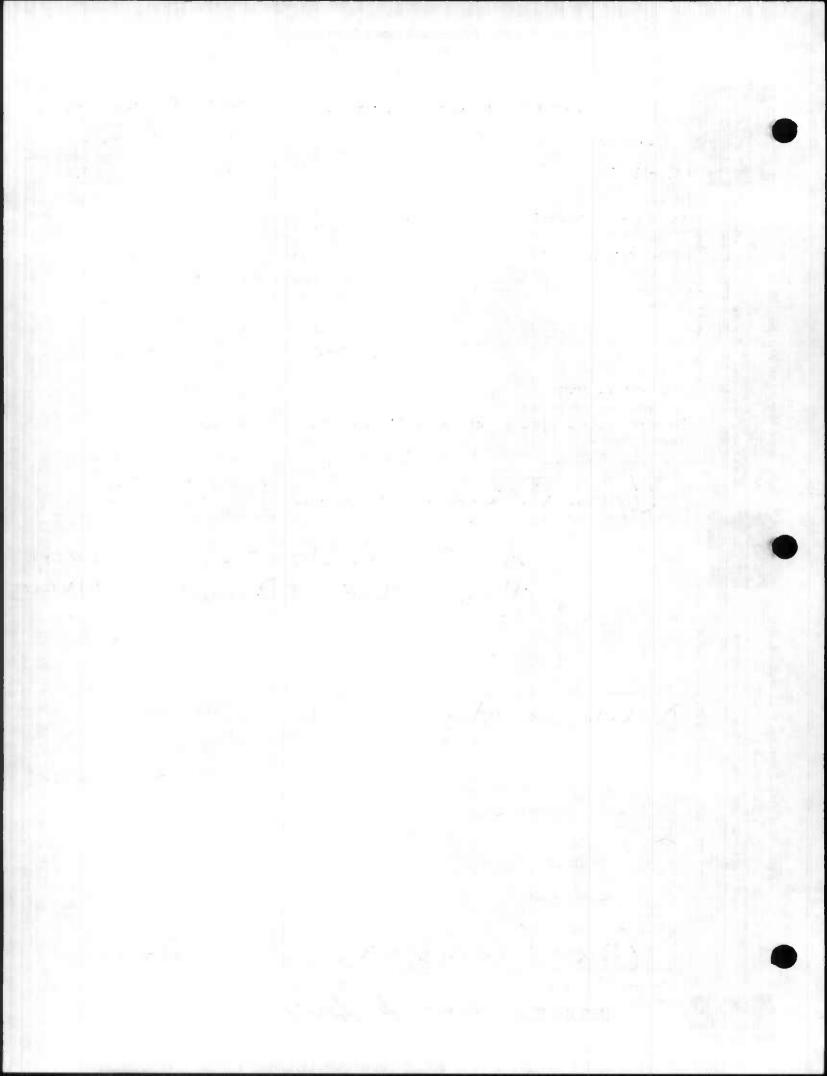
Registrar

State

Casper E. Cline III

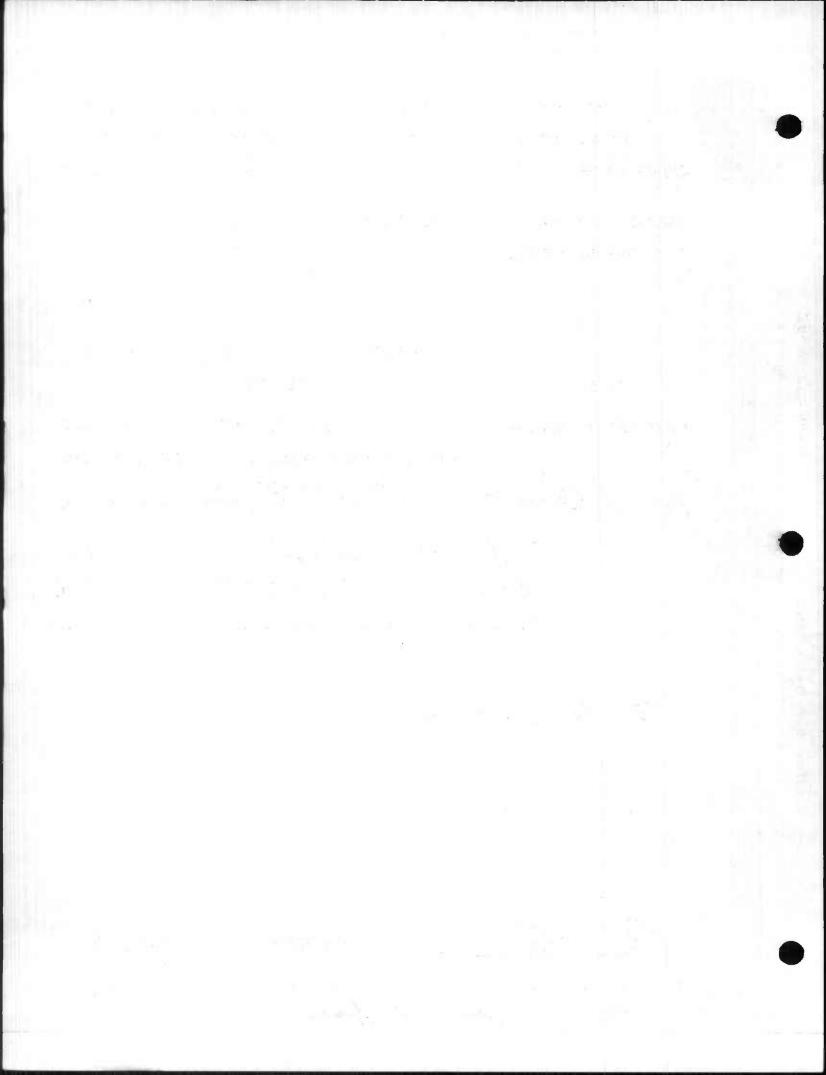
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31. Data tilad (Month, Day, Yaar)



				State	of Marylan		rtment of I tificate of	Health and Death		giene Reg. No.	9 08	559
	Physic /Medi		Decedent's Neme (First, Mide IDA BEAT	RICE	RICHAR	DSON			2. Dete of De Month Febru	Dey	Year 1999	ima of Deeth
	Exami	ner	4a. Fecility Neme (If not institution PENINSULA R			ENTER		4b. City, Town, or SALIS			of Deeth	
	Funeral Director		5. Sociel Security Number 214-12-5382	6. Sax 1 M 2 F	7. Age (In yrs. 89	last birthday)	If Under 1 Yaar Months Deys			h y, Year)		State or Foreign
	pue **		Usuel Residence of Decedent 10a. State 10b. Count	/	10c. Cit	y, Town or Loc	ation				10d Inc	ide City Limits
	Manyl sho	tor	MARYLAND SOME	RSET		PRINCES						Yes 2□No
	or 28	Directo	10e. Street end Number				10f. Zip Code			10g. Citizen of \	13 2	
	eath w	Funeral	11794 EDGEHILL		cedent Ever in U,	C 12 W		L853	posity Vac or No		SA e - American Ind	lon
020	s 1 and 2 should be filed within 72 hours efter death with the Marylend Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evantiver must be notified at	by	1 □ Never Married 2 □ Ma 3 ◯ Widowed 4 □ Divorce	rried Armed F	orces? 2 X No Sive)	Yes, specify Cub	Hispenic Origin? (S en, Mexican, Puerl Specify:	o Rican, etc.)	Specify	ck, White, etc.	
21215-0020	vithin 72 ho ne. nan "natur e Med cal	Completed	15. Decade (Specify only higher Elementary/Secondery (0-12)	nt's Education est grade completed College	() (1-4or 5+)	(Give k life. D	O NOT use retire	during most of war	rking		usiness/Industry	
	Hygier ther the		17. Fethar's Neme (First, Middle	Last)	•	SEAMS	TRESS	18 Mother's Ner	na (First, Middle,		FACTORY	
lan	world be filed Mental Hygi arked other atic event, i	To Be	GEORGE WILLIAM					LIZZIE		maioen Saman	10/	
Maryland	2 should have and hav		19a. Informent's Name/Relation	ship (Type, Print)		19b. Meiling	Address (Street	and Number or Ru	ıral Route Numbe	er, City or Town,	State, Zip Code)	
	1 and Health em 27		BETTY RENSHAW/ 20a. Method of Disposition	DAUGHTER	20b. P		MT. VER	NON ROAD	, PRINCE		MD. 21	
mor	00		1 Burial 2 ☐ Crametion 4 ☐ Donetion 5 ☐ Other (3 Removel from	Stete	emetery, crem	atory or other pla	∞) GARDENS			, MARYLA	
Baltimore,	permit. Peg Department Important: i any Injury o	1	21. Signeture of Funeral Service		0. ,	22.	Name end Addre	ess of Facility			,	
·	82589	(Janes X. X	herra	M00295	11	673 SOME	RSET AVE	. PRINC	ESS ANN	E. MD. 2	21853
,	Physician /Medical	0	Pert1. Enter the disease, o shock, or heert feilure. Lis	r complications that t only one cause on	caused the death	n. Do not ente	r the mode of dyi	ng, such es cardia	or respiratory ar	rest,	Appro	eximete el Between t end Death
	Examiner		disease or condition resulting In death)	a. Th	Due to (o	r as a consequ	ience of):	wies			/	NU
	bed sit	Examiner		. Host	Op X	ligmo	id (olecto	~		5	d
o,	be executed sician and bunal-transit	Exar	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events	0.	OVer to (or	as consequ	ence of):	. 8	10		\sim	
8760	cate be ohysicia the bur	dical	Ceuse (Diseese or Injury thet Initieted events rasulting in death) Last	s rec	Due to (or	as a consegu	ence of):	hoes	skus		d	yes
9	leath certific attending p	(D)	, , , , , , , , , , , , , , , , , , , ,	L								U
Box	d for u	Physician/M	Pert II. Other significent conditi	one contributing to	dooth but not roo	. Iting in the	daglijas aktor al	son la Post I	non Didd	-h	madhida an abn a	
0	es that the dexigned by the a	Phys	0 00	4F, (-	ven in Fent i.	1 🗆		ntribute to the ca 3 ☐ Probably	4 Unknown
	signed be de	by	COIV, G	77, 0	-171,	come	nua					
Records,	e law requires that the death certificate hes been signed by the attending physige 2 should be deteched for use as the	Completed								en eutopsy rmed?	24b. Were eut available completic of death?	prior to in of cause
Vital	Pag Pag		25. Wes case referred to medical	M.				00 Di 4 D	101		1 ☐ Yes	2□ No
	Physician: this certific ral director,	To Be	examiner?	Hospital	Pinpatient 2□	ER/Outpetlent	3□ DOA Ott	ner	ath <i>(Check only o</i> lome 5☐ Resid		ar (Specify)	
ion of	유부를		27. Manner of Deeth 1 Naturel 5 Pendi 2 Accident invest	28a. Dete (Moi igation		28b. Time of Injury	28c. Inju Wo		28d. Dascribe h			
Division	To the Hoapkal or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicida 6 ☐ Could 4 ☐ Homicide detern	nined 289. Plac	e of injury - At ho ding, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (S City or Tox		per or Rural Route	Number,
	Hoapi 24 hou Funer. tely fill	edicai	29a. Certifier 1 Certifyi (Check only one)	ng Physician: To th Examiner: On the i	pasis of examinet	wledge, death ion end/or Inve	occurred et the til	me, date and place opinion, death occu	, and due to the cred et the tima,	ceuse(s) and ma date end place,	nner es stated. end due to the ce	euse(s)
	othe othe omple	Med	29b. Signatura and title of certific		nner stated.		29c. Licens	se number	15	29d. Date signe	d (Month, Day, Y	oar)
	- s - ō		V Ca	(1)			DI	41567		2/2	7/99	
,			30. Name and address of person	who completed cau	use of death (Item	23a) (Type, P	rint)			_/	1	
			Nicholas J. 31. Dete filed (Month, Day, Year	Dudo	S M.	D.		- Carroll	51.	dali	bury,	Md.
	Sta Registr		MAD -	1 1999	Registrer's Signer	1 4	Some	61			9	

214-12-5382



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** BURTON CLYDE ROBINSON 11:01PM Feb. 23,1999 /Medicai 4e. Fecility Neme (If not Institution, give street end number) Genesis 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Eldercare-Meridian of Corsica Hills Centreville Queen Anne's 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 5. Sociel Security Number Birthplece (Steta or Foreign Country) **Funeral** XXM 2 F 220-32-0405 Yrs. Director MarylaND Dec.9,1906 Usuel Residence of Decedent the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryle Department of Heelith and Mentel Hygiene. Important: if item 27 is merked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, it is the continued in any injury or other traumatic event, it is the continued in the Queen Anne's 1 ☐ Yes 2016lo Director Queen Anne 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1704 Ruthsburg Road 21657 U.S.A. Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2€ No Specify: by Specify: White 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Businass/industry Trucking Elamentery/Secondary (0-12) Collaga (1-4or 5+) Self-employed truck driver 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) John Robert Robinson Inez Bromley 19e. Informant's Name/Reletionship (Type, Print) Daughte 19b. Meiling Address (Straat and Number or Rural Route Numbar, City or Town, Stete, Zip Code) in-law 633 Granny Branch Rd., Church Hill, Md. Frances E. Robinson Feb. 26, 1999 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Chesterfield Cemetery Centreville, Md. 22. Neme end Address of Fecility Fellows, Helfenbein & Newnam Funeral Home 408 S. Liberty St., Centreville, Md.21617 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** weed /Medical Immediete Ceuse (Final disease or condition resulting in daath) Prouindria Examiner Due to (or es a consequence of) Examiner that the death certificate be executed Sequentially list conditions, if any, leading to immadiata ceusa. Entar Underlying Ceuse (Diseese or injury that initieted events resulting in daath) Lest physicien s the buriel Physician/Medical signed by the el Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by Bivitomin defenera 24b. Were eutopsy findings evailable prior to completion of cause of daath? Completed 24e. Wes en eutopsy 1 ☐ Yes 2 ☑ No 1 Yes 2 No or Attending Physician: 25. Wes cese referred to medical exeminer? 26. Place of Death (Chack only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) Certification: To 1 Yes 2 No this funeral 28e. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Natural 5 Pending efter death.

I Director: After in by the fu 1 ☐ Yas 2 ☐ No investigation 2 Accident 6 Could not be datarminad 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) filled in by 4 Homicida 24 hours To the Hospi within 24 hou To the Funer completely fil edicai 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred at tha tima, data and place, end due to tha ceuse(s) end menner es steted. 29e. Certifiar (Check only one) 2 Medical Exeminer: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the causa(s) and menner stated. 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 442587 30. Neme end address of person who completed cause of daeth (Itam 23a) (Type, Print)

State Registrar

FEB 2 6 1999

Russell Schilling,

31. Dete filed (Month, Dey, Year)



G. Sparks

M.D.; 2540 Centreville Rd., Centreville, Md. 21617

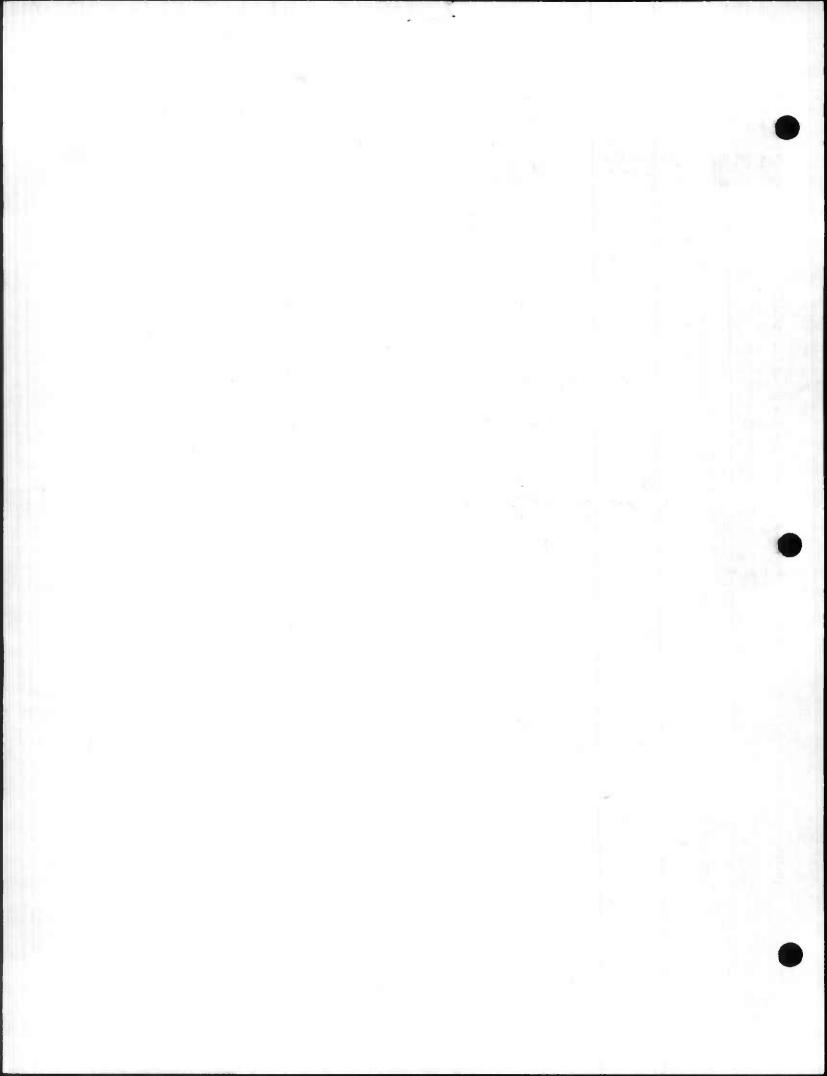
Baltimore, Maryland

Box 68760.

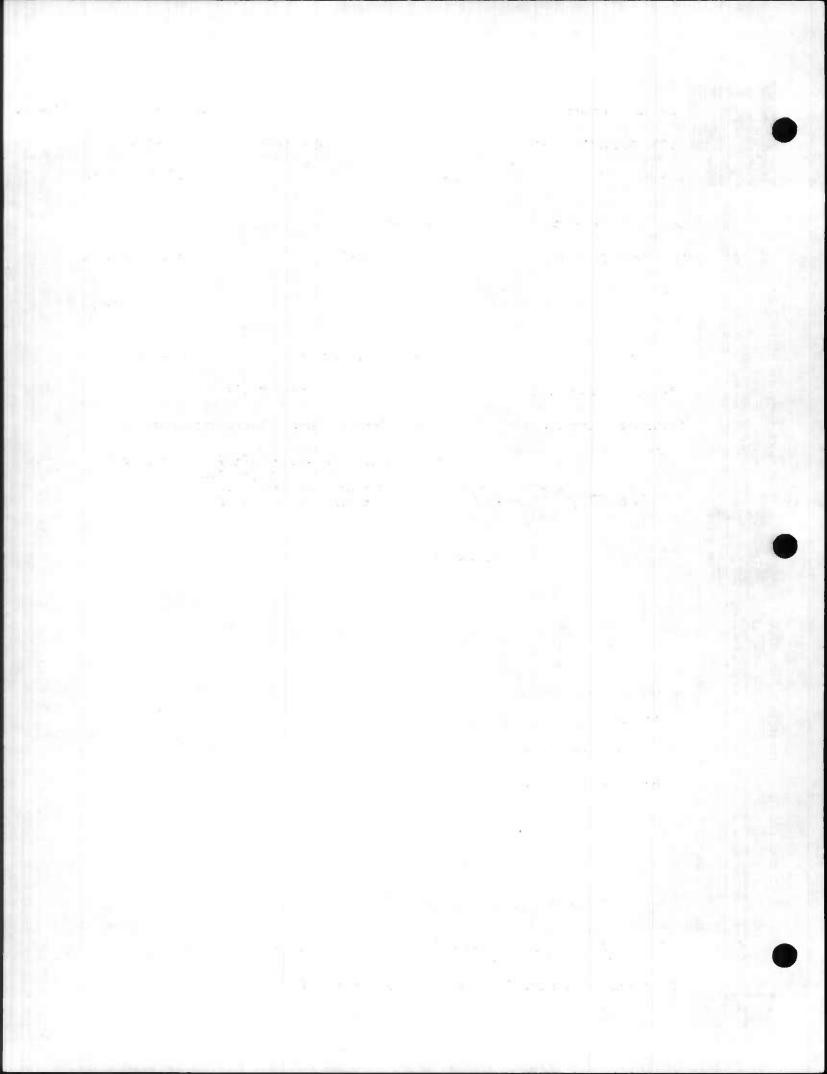
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Records,

Division of Vital



	1. Decedent's Name (First, Middle, I	ast)		Cert	tificate of	Dealli	2. Date of De	Reg. No.		3. Time of Death
ian		asij					Month	Day	Year	
ical	Helen Sapountzi 4a Fecility Neme (If not Institution, g		1			4b. City, Town, or	Februa		1999	12:00noo
ner			er)							
	1920 Peveril Co. 5. Social Security Number 6.		Ann /In ure	last birthday)	If Under 1 Yea	Huntingt	OWN	Calv		ana (Stata or Famin
		1□ M 224F		Yrs.	Months Days		(Month, De	y, Year)		aca (State or Foreig ry)
	578-46-2172 Usual Residence of Decedent		75				June 24	, 1923	Greec	:e
	10a. State 10b. County		10c. Cff	ty, Town or Loc	ation				10	d. Inside City Limits
to	Maryland Calvert		Н	intingt	าพท					1 ☐ Yes 2 🖾 No
Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Count	ry?
D	1920 Peveril Cour	·t			20639			United	Stat	AC
5	11. Marital Status	12. Wes Decede	nt Ever in U	I,S. 13. W	/as Decedent of	Hispanic Orlgin? (S ban, Mexican, Puer	Specify Yes or No		e - America	an Indien,
	1 Never Married 2 Married	1 ☐ Yes 21			Yes 2XXNo		(O ricall, etc.)		ck, White, e	otc.
	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yeer or Date	s:		LI 163 ZMAN	Specify.		Specif	Whi	te
and disconnection	15. Decedent's (Specify only highest g			16a. Decede	ent's Usual Occu	upation e during most of wo	rkina	16b. Kind of B	usiness/Ind	ustry
	Elementary/Secondary (0-12)	College (1-4	or 5+)			e during most of wo ed)				
	12			Denta	l Assist			Dentis		
3	17. Father's Name (First, Middle, Las						me (First, Middle	, Maiden Suman	ne)	
0	Stamatou Sapoun					Maria V				
	19a. Informant's Name/Relationship					et and Number or Ri				Code)
	Nickolas Demer (Nephew)	20h F	1920] Placa of Dispos		Court, H	untingto Date			um State
	20e. Method of Disposition 1 🛱 Burial 2 □ Cremetion 3	☐Removel from Sta	te	cemetery, crem	atory or other pl			20c. Location	- City of Tov	wn, State
	4 Donetion 5 Other (Spec		Gat	e of He	eaven Ce	emetery	3/3/99	Silver	Sprin	g, Maryla
	21. Signature of Funeral Service Lic	ensee	71			ress of Facility De' Deer Park		eral Hom	e	
	Nobert (V	· We Vo	P			ourg, MD				
iner	disease or condition resulting in death)	a Hyper		or as a consequ	uence of):					
Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury		Due to (d	or as a consequ	uenca of):					
Medical	thet initiated events resulting in death) Last	c	Due to (d	or es e consequ	ence of):					
by Physician/M	·									
1981	Part II. Other significant conditions	contributing to deat	n but not res	sulting In the un	derlying cause g	given in Part I.				the cause of death
	Diabetes						10	Yes 2CINO	3∐ Prob	ably 4 Unknow
	Hypercholestero	lemia					24a. Was	s an autopsy ormed?	eve	re autopsy findings silable prior to npletion of cause death?
Completed	n 1 r 661 1						10	Yes 2⊠No		Yes 2 No
ပိ	Renal Insuffici	ency				Of Diseas of Do	ath (Check only			7165 2010
To B	examiner? 1XX Yes 2 □ No	Hospital:	ationt 2	ER/Outpatient	3□ DOA O	ther	Home 5 X Res		has /Sansih	-
	27. Manner of Death	28a. Dete of I (Month,		28b. Time of	28c. Inj			how injury occu		7
91	14 Neturel 5 ☐ Pending 2 ☐ Accident investigati		Dey Year)	Injury		Yes 2 No				
Cermication	3 Sulcide 6 Could not determine	28e. Placa of building,	Injury - At h etc. (Specif	ome, farm, stre	et, factory, office	9	28f. Location (City or To	(Street and Num wn, State)	ber or Rura	l Route Number,
edicai	29a. Certifier 1∑ Cartifying F (Check only one) 1∑ Medical Ext	Physician: To the beaminer: On the basis and manner	of examina	owledge, death ation end/or Inve	occurred at the estigetion, in my	time, dete end plece opinion, deeth occi	e, end due to the urred at the time,	cause(s) end m date and placa,	enner es sta and due to	ated. the cause(s)
Me	29b. Signeture and title of certifier	n			29c. Licer	nse number		29d. Date signe	ed (Month, I	Day, Year)
_ [\ // /	1	ens	7		51620		Fohmus	26	1000
	30. Name and address of nercon wh	n completed source	of death /lter	n 23a) (Tuna E		51638		Februar	y 20,	1999
	30. Name and address of person whe Reba Mukerjee,				Print)	, MD 2074	6	reditual	y 20,	1999



State of Maryland / Department of Health and Mental Hygiene 08562 Certificate of Death

Physician	
/Medical	
Examiner	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic avent, the Hedical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Staltimore, Maryland 21215-0020 Physician /Medical Examiner To the Hospital or Attanding Physician: The law requires that the death cartificate be associated within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunta-transit Division of Vital Records, P.O. Box 68760,

3. Time of Deeth Yeer
999 9:30 PM
of Death
mery
Birthplace (State or Foreign Country)
ashington, DC
40d Incide City Limits
10d. Inside City Limits 1 ☐ Yes 2X No
het Country?
- American Indien, , White, etc. White
iness/Industry
Shop
)
Stete, Zip Code) 22191
d, MD Funeral est
ease 2 years
1
tribute to the cause of death? 3 Probably 4 Unknown
24b. Were eutopsy findings available prior to completion of cause of death?
1 ☐ Yas 2 ☐ No
r (Specify)
od
or or Rurel Route Number,
ed

State

Registrar

11251 Lockwood Dr., Silver Spring, MD 20901

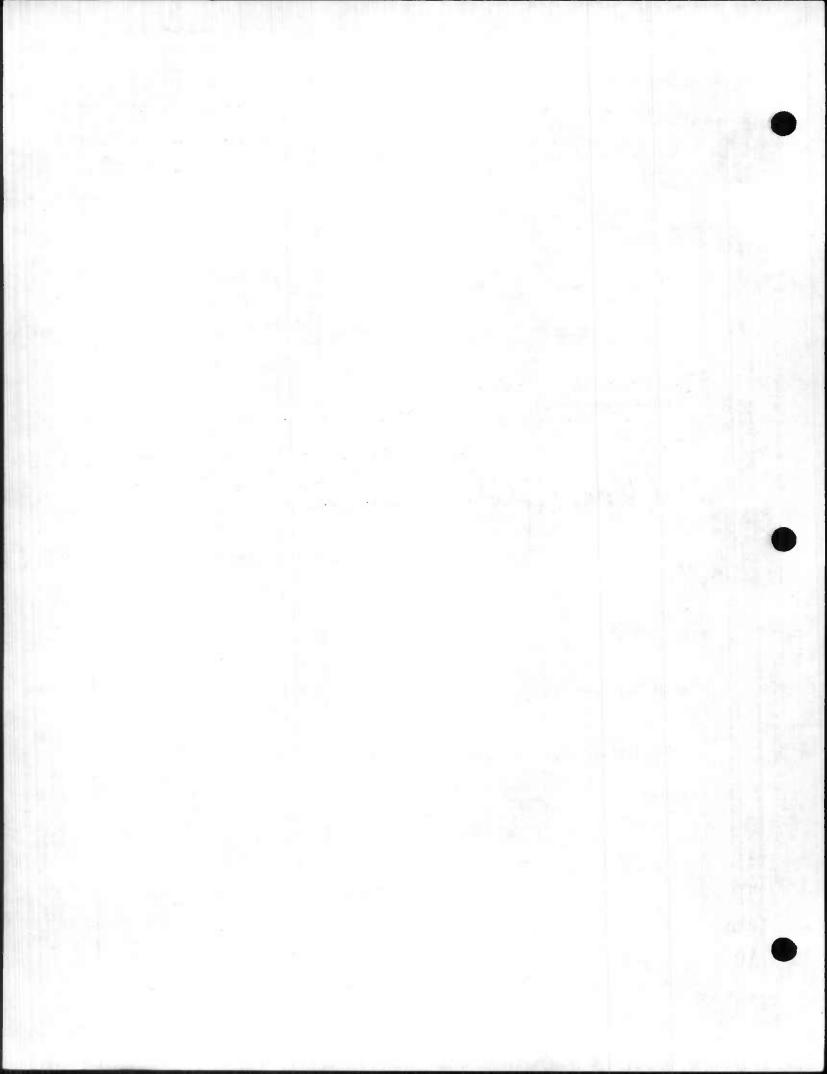
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signeture

Pamela M. Mulshine, MD.

MAR 0 5 1999

31. Date filed (Month, Day, Year)



		State of Maryland /	Department of I		ental Hygie		8563
	1. Decedent's Nema (First, Middla, Last)	00/11/104100/		2. Date of Death	NO.	3. Time of Death
Physician	FRANCES	W. SC	HLATTER		Month MARCH	3, 199	
/Medical Examiner	4e Facility Neme (If not institution, give		IIIAIIEN	4b. City, Town, or Loc		4c. County of Dec	-
Examine		S HOSPITAL	2500	SILVER S	EDRING	MONT	GOMERY
Funeral	5. Social Security Number 6. Sa		birthday) If Under 1 Yeer	If Under 24 Hrs.	8. Dete of Birth		rthplaca (Stete or Foreig
Director	577-48-9567	□M 20F	Yrs. Months Deys		(Month, Day, Ye		GEORGIA
D	Usual Rasidanca of Decedant						
abon T	10a. Stete 10b. County	10c. City, To	own or Location				10d. Inside City Limit
oto	MD. MONTGO	MERY	SILVER S	PRING			1 X Yas 2 □ N
or 28a-f show be notified at Director	10e. Street and Number		10f, Zip Code		10g.	Citizen of What C	ountry?
	9506 CAROI	INE AVE.		0901		U.S	
her death of the fact that the	11. Marital Status	12. Was Decedent Evar in U,S. Armed Forces?	13. Wes Decedent of If Yes, specify Cut	Hispanic Origin? (Spectan, Mexican, Puerto F	cify Yas or No- lican, etc.)	14. Race - Am Black, Wh	
		1 ☐ Yes ŽÕ No If Yes, Give	1 ☐ Yes 2 No	Specify:		Specify: _	
d by	3. Widowed 4 □ Divorced	Yeer or Detes:				WHITE	
Tz.	15. Decedent's Edu (Specify only highest grad	cation 16 a completed)	 Decedent's Usuel Occu (Giva kind of work done life. DO NOT use retire 	pation during most of workin	165	. Kind of Business	s/Industry
ed within 72 ho ygiene. wr than "natur f, the Medical. Completed	Elementery/Secondery (0-12)	College (1-4or 5+)				DDTXAM	E SCHOOL
	17. Father's Neme (First, Middle, Last)	4	TEACHE	18. Mother's Name			E SCHOOL
Be ever		II WITOUC					
d Men d Men marks marks	HARMON	H. WICKS	9b. Meiling Address (Stree	ANNI			PELAND
T is a	19e. Informent's Neme/Relationship (7)						
Teat Park	BERTHA A. SERI 20e. Method of Disposition		376 E. P. of Disposition (Name of	TCCADILLEY		. NCHES TI	ER, VA.226
2 = 0	1 ☐ Buriel 2 ☐ Cremetion 3 ☐ F	Removel from State	etery, cremetory or other pla			. Looulion Ony o	
duny duny	4 Donetion 5 Other (Specify)		AMBERS CREI		3/4/99	RIVERDA	ALE, MD.
appar my fr my fr	21. Signeture of Funeral Service Licens	00 1 0	22. Neme and Addr	ess of Fecility			20910
00240	M.M. Cha	merce MOOO!	91 CHAMBERS	S FUNERAL	HOMES,	P.A., S.	ILVER SPR
	23a. Pert1. Enter the disease, or compl shock, or heart failure. List only or	icetions thet caused tha deeth. D	o not enter the mode of dy	ing, such es cardiac or	respiretory errest,		Approximete M Interval Between
hysician							Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition	CARDIO-V	ASCULAR CO	LLAPSE			5 MIN.
	resulting in deeth)	Due to (or es	a consequence of):				1
executed n and ial-transit Examiner		ACUTE MY	OCARDIAL I	NFARCTION	J		3 DAYS
sician and burial-transit	Sequentially list conditions,	Due to (or as	a consequence of):				
cian cian	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	•					
physicia s the bur	thet initieted events resulting in death) Last						
leath certifice attending ph d for use as th iclan/Med		4					
tteno or us							
requires that the death certificate seen signed by the attending phys hould be detached for use as the eted by Physician/Medic	Part II. Other significant conditions con	tributing to deeth but not resulting	g in the underlying cause g	iven in Part I.	23b. Did toba	cco use contribu	te to the cause of deati
res that the designed by the at I be detached I by Physic	BREAST CAN	CER			1 Yea	20 No 3□1	Probably 4 Unknow
be be		0211					
been s should leted	ENDOMETRIA	I CANCER			24a. Wes en a performed		. Were autopsy findings eveilable prior to
has by ge 2 st	23120121121						completion of cause of death?
The law requir	RADIATION	ENTORITIS			1 ☐ Yes	2 No	1 ☐ Yes 2 ☐ No
Physician: The ribis certificate oral director, page 1: To Be Co	25. Wes case referred to medical axeminer?			26. Place of Death	(Check only one)		
To I	1 ☐ Yes 2]X] No	lospitel: 1 Minpatient 2 ☐ ER/	Outpatient 3□ DOA	ther: 4 Nursing Hon	ne 5 🗆 Residence	a 6 □Other (Sp	ecity)
ter th	27. Menner of Death 1 ☑Neturel 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28t	b. Time of lnjury 28c. Injury	ury at 2	8d. Describe how i	njury occurred	
Attending or death. ector: Afte by the fune iffication	2 Accident invastigation			Yes 2□No			
er de recto by ti	3 Suicide 6 Could not be determined	28e. Plece of Injury - At home, building, etc. (Specify)	, ferm, street, fectory, office	2	8f. Location (Stree City or Town, S		Rural Route Number,
tal or Attending P is after death. al Director: After ided in by the funer: Certification:		gi cit. (oposij)		State of the			
hour hour	29a. Certifier	sician: To the best of my knowled	dge, deeth occurred at the t	time, date and place, e	nd due to the caus	e(s) and mennar	ns stated.
he Hosp in 24 hou he Funer pletely fil	one) 2 Medical Exami	ner: On the basis of examinetion and mannar stated.	end/or investigetion, in my	opinion, deeth occurre	ru at the time, date	and pieca, and di	Je (O IIIe Cause(S)
To the Company	29b. Signetura and title of certifier			ise number		Dete signed (Mor	
	y FEV	no	Do	0 10690	N	NAR 3	1999
17	30. Neme end eddress of person who co	ompleted cause of death (Item 23/					
	29b. Signetura and title of certifier 30. Neme end eddress of person who co	and mannar stated.	29c. Licen	0 10690	29d.	Dete signed (Mor	nth, Day, Year) - 1999

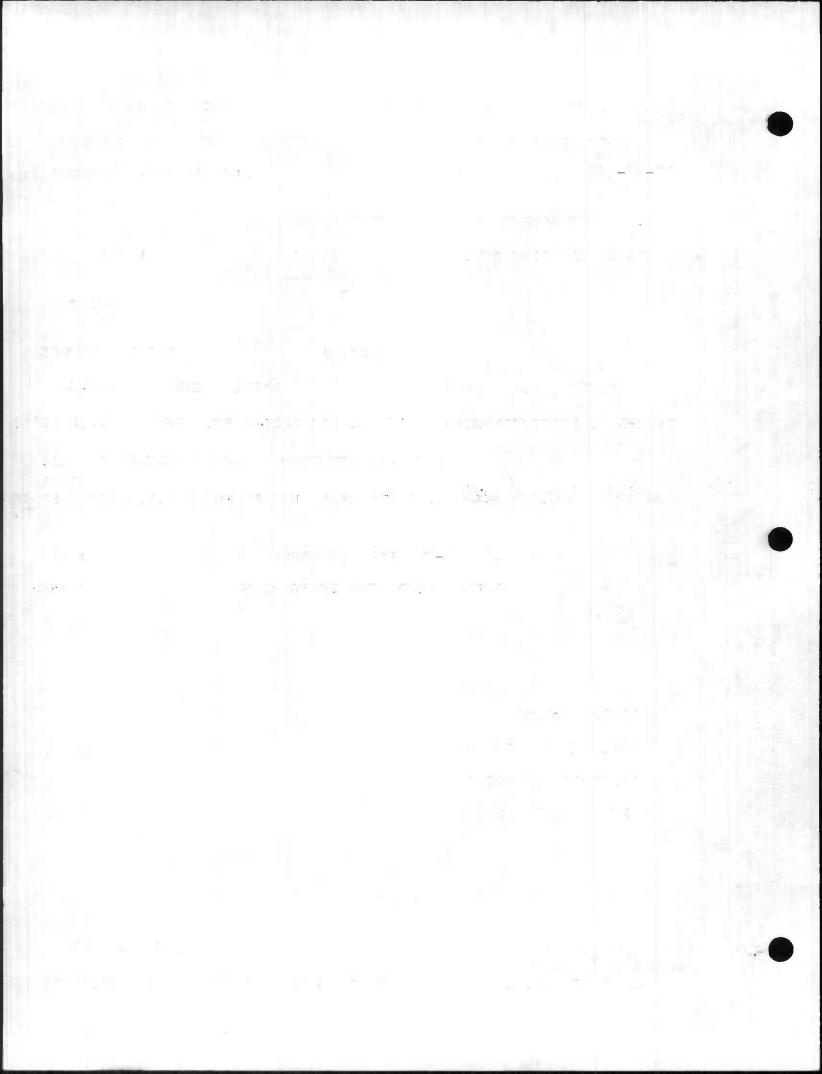
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32. Registrar's Signeture



DHMH 16 Ray 6/95

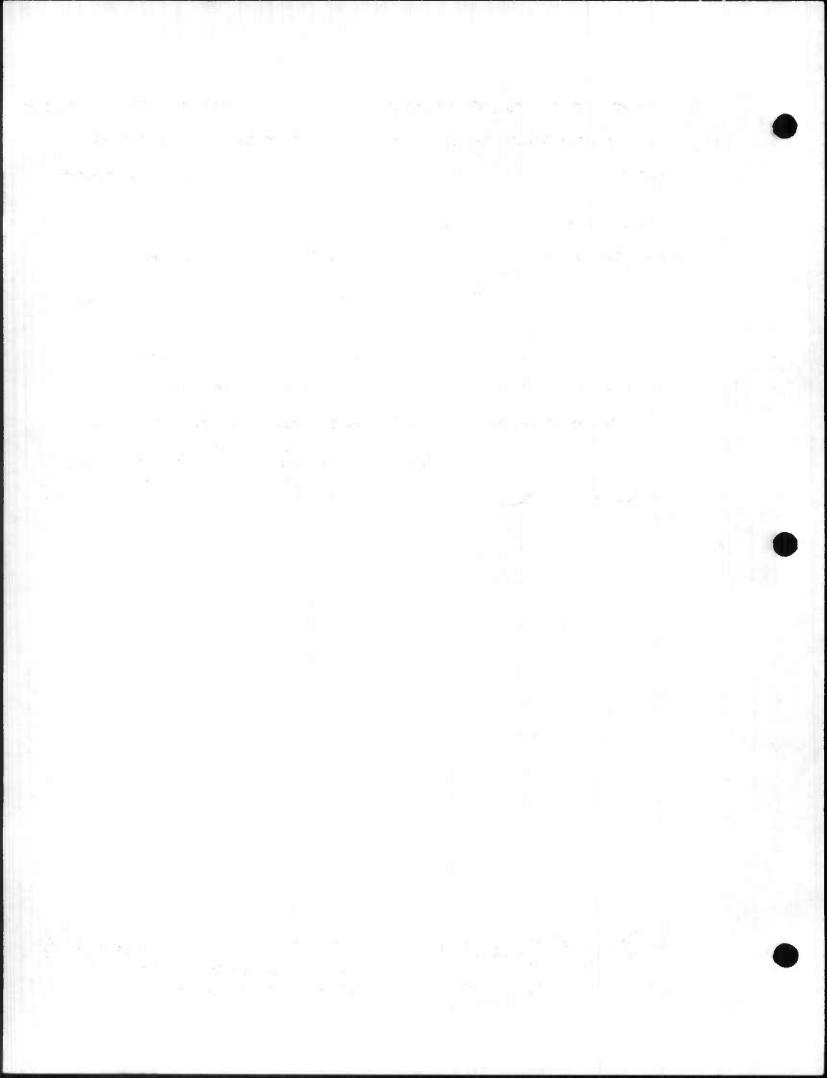
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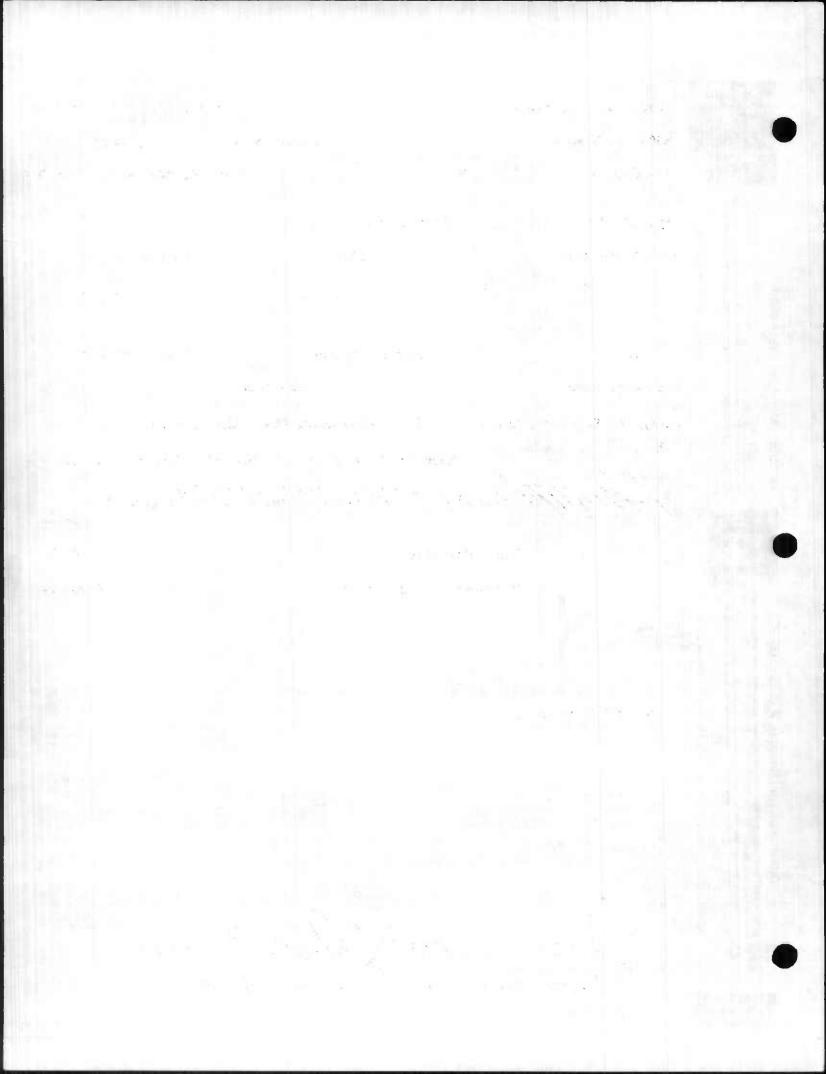
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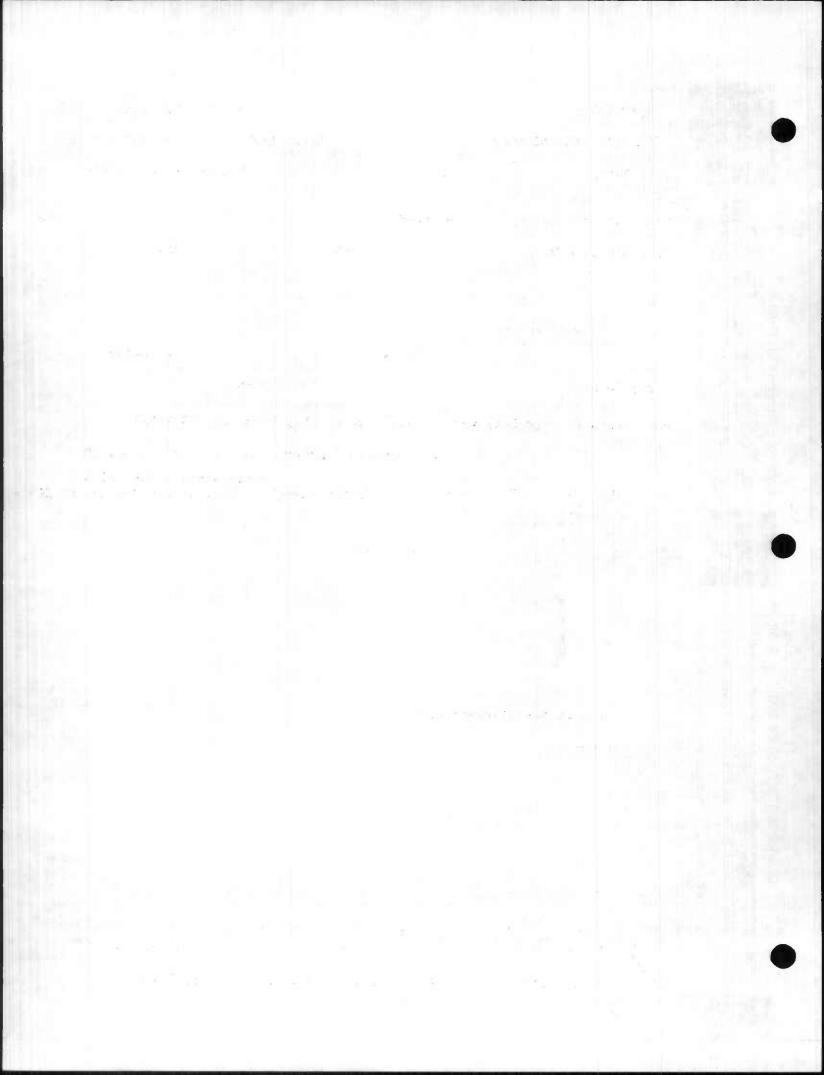
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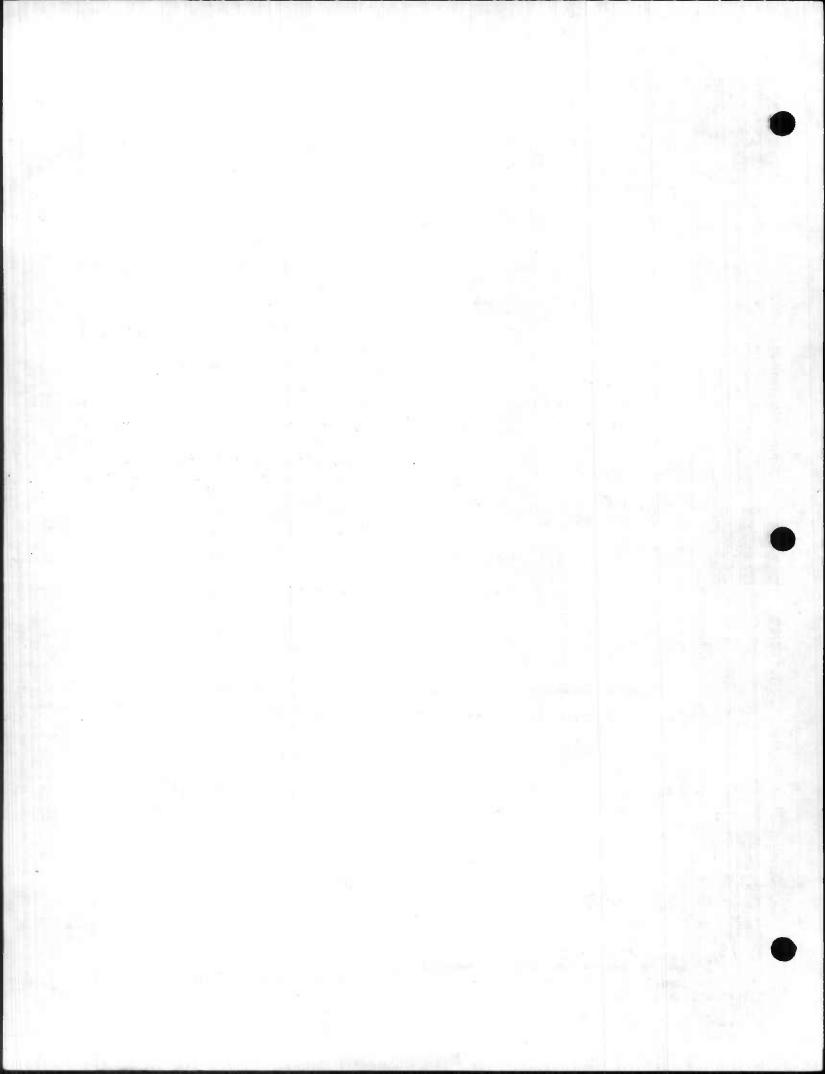
State of Maryland / Department of Health and Mental Hygiene 🔾 🔾

			Ce	rtificate	of Death		Reg. No.	08566		
	1. Decedent's Name (First, Middle, Las	t)				2. Date of De Month	eath Day	3. Time of Deeth		
Physician /Medical	MARY SEYMORE					FEBRUAR		999 11:21A		
Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, Town,	or Location of Deat		of Death		
46	ROCKVILLE NURSIN	NG HOME			ROCKVIL	LE	MONTO	GOMERY		
Funeral Director	5. Sociel Security Number 6. St 577-10-4473 Usuel Residence of Decedent	7. Age (in	yrs. last birthday 84 Yrs.	Months i		Hrs. 8. Dete of Bi (Month, Di Oct 25	rth ey, Year) , 1914	9. Birthplace (State or Fore Country) Greece		
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1 and Health Health other tr	Anna Maria Colev		20b. Place of Disp cemetery, cre			Date Date		City or Town, State		
	1 🕅 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval Irom State	Fort Li	ncoln	Cemetery	Mar 3	Brentwo	ood, MD		
permit. Page Department of Important: If any Injury or once.	21. Signefure of Funeral Service Licen	Donne						eral Home Spring, MD 209		
death carificete be executed e attending physician end d for use es the burial-transit	23a. Pert1. Enter the disease of complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Immediate Ceuse (Finel disease or condition resulting in death)									
death cert e attendin od for use	Part II. Other significant conditions or	d	use given In Pert I.	23b. Dld	tobacco usa co	ntributa to the causa of dea				
es that the de igned by the be detached by Physic		ascular Acc	cident			_ 1□	Yes 2 No	3 ☐ Probably 4 ☐ Unkn		
w requir						perf	s en eutopsy ormed?	24b. Were autopsy finding aveilebte prior to completion of ceuse of deeth?		
							Yes 201No	1 ☐ Yes 2 ☐ No		
Physicien: The la this certificate has ral director, paga 2.	25. Wes case referred to medical exeminer?	Hospitel:			1	Deeth (Check only				
	1 Yes 2X No 27. Menner of Deeth 1X Neturel 5 Pending	1 ☐ Inpatient 28e. Dete of Injury (Month, Dey Ye	2 ER/Outpetie 28b. Time o Injury		C. Injury et Work? 1 Yes 2 No	ng Home 5 ☐ Res 28d. Describe	how injury occur			
tal or Attending P rs effar death. el Director: After t led in by the funera Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury building, etc. (S	At home, ferm, so				(Street and Numb own, Stete)	er or Rural Route Number,		
To the Hospital or within 24 hours eff. To the Funeral Dir completely filled in Medical Cert	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	rsician: To the best of m iner: On the basis of exa and menner stated	aminetion end/or in	th occurred et ovestigetion, Ir	the time, dete and p	lece, end due to the occurred et the time	ceuse(s) end ma , dete end place,	nner es steted. end due to the ceuse(s)		
o the	29b. Signature and title of ceptifier	///		29c. I	License number		29d. Dafe signe	d (Month, Dey, Year)		
33	1000	RUL	14.0		020516			1, 1999		
/	30. Neme and address of person who of Joel R. S				own Rd, Be	ethesda, l	MD 20814			
State	31. Date filed (Month, Dev. Year) MAR 0 3 199	32. Redistrer's	Signeture 4	Lon	2/2/					



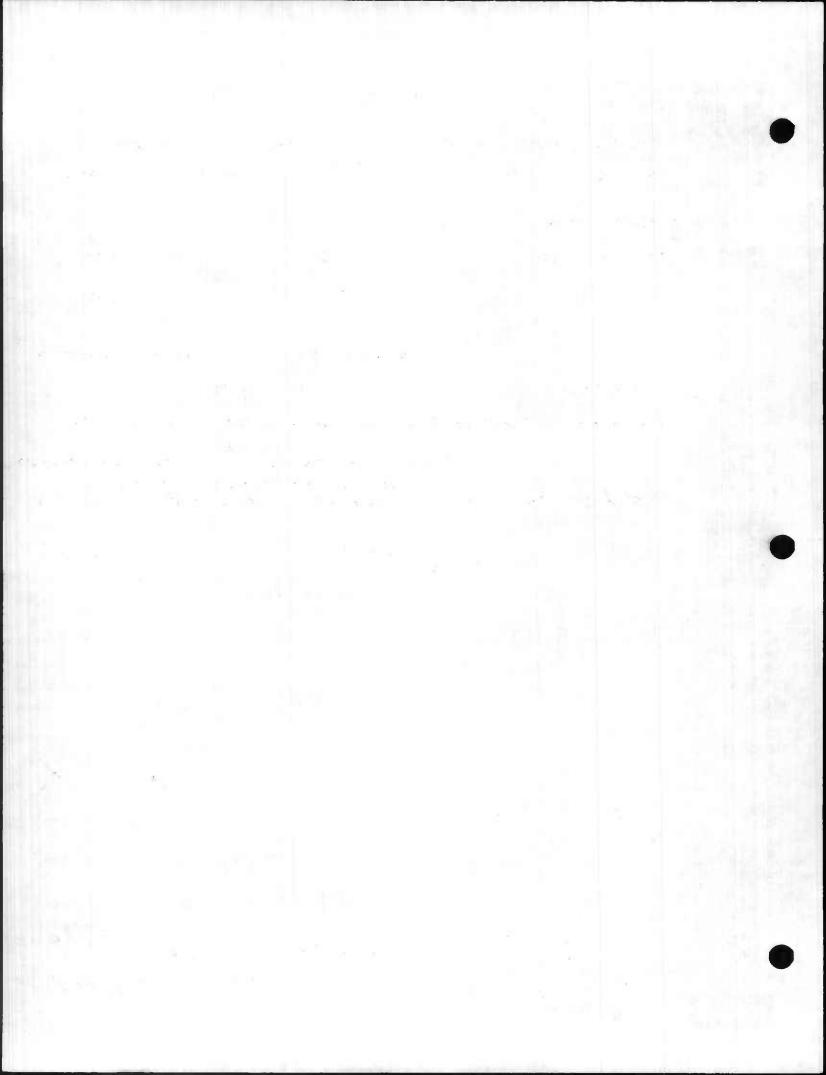
State of Maryland / Department of Health and Mental Hygiene 9 08567

						Cer	tificate of	Death		Reg. No.		0001
			1. Decedent's Neme (First, Middle, La.	et)					2. Date of De		Year	3. Time of Death
	Physicia Medic		Eileen R. Share	r					March	4, 1999	y ear	2:50 AM
	Examin		4e Facility Neme (If not institution, give	street and number)				4b. City, Town, or L	ocation of Deal	h 4c. County	of Death	
			Montgomery Gene	ral Hospit	al al			Olney		Mon	tgome	ery
	Funeral Director		3/9-36-3490	ex 7. Age □M 2√2 F	(In yrs. last	birthday) Yrs.	Months Days		8. Date of Bi (Month, Di Dec. 3	ay, Year)	9. Birthp Coun Wash:	olace (State or Foreign intry) ington, DC
	P 2		Usual Residence of Decedent 10a. Stete 10b. County		10c. City, To	own or Loc	cation				1	Od. Inside City Limits
	danyl daho	ō	MD Montgo		C.	1	Spring					1 ☐ Yes 2 ☑ No
	28. 5	Je.	MD Montgo	mery	51.	TAGI	10f. Zip Code			10g. Citizen of V	Mhat Cour	ntry?
	death with the Maryland ms 23a or 28a-f ahow constitut be notified at	DIE	14800 Pennfield C	ircle, #10	2		2090	06		US	Α	
	deat	Funeral Director	11. Meritel Stetus	12. Wes Decedent E		13. W	Vas Decedent of i	Hispanic Origin? (Spean, Mexican, Puerto	pecify Yes or No Rican, etc.)		ce - Americ	can Indian,
Maryland 21215-0020	n 72 hours after death with the Marylar *naturet', or flems 23e or 28e-f show notcel Examinet must be notified at	by	1 ☐ Never Married 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:)		□Yes 2√2No			Specify	V*	hite
2	72 h natu	etec	15. Decedent's Ed (Specify only highest gra		1	(Give I	ent's Usual Occu	during most of work	king	16b. Kind of Bu		
121	filed within Hygiena. ther than one, the Man	Completed	Elementary/Secondary (0-12)	College (1-4or 5+			OO NOT use retire			-		Gas & Light
N D	Il Hygie other t		17. Father's Neme (First, Middle, Last)			Claim	s Adjust	18. Mother's Nam	a (First Middle	Company		
a	S E D >	o Be	Horace Rowell					Anna Ma		, made of the original	,,	
2	2 should be and Menta is marked sumstic ev	ř	19e. Informent's Neme/Reletionship ((voe. Print)	1	9b. Mailin	o Address (Stree	t and Number or Ru		er. City or Town.	State. Zic	Code) 20906
2	2 4 2 5		Robert G. Sharer	(husba				eld Circle				
w .	-125		20e. Method of Disposition		20b. Place	of Dispos	sition (Name of natory or other pla		Data	20c. Location -		
E .	- X		1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specifi				lemorial		3/8/99	Olney,	MD	
<u>a</u>	permit. Pag Department Important: It any injury o		21. Signeture of Funerel Service Licen	900	~//	22.	Name and Addre	ess of Fecility Fra	ancis J	. Collin	s Fur	neral
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		1	234 Part1. Enter the displace of com- shock, or heart feilers. Lift only	icutions that caused to	the deeth. D					irrest,	1	Approximate Intervat Between
	hysician											Onset and Death
	/Medical Examiner		Immediate Cause (Finel disease or condition	. ADULT	Rest	PIRA	TORY	DISTRETS	SYN	onome	2	2 WEEKS
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	nsit	nlne		b. multi	PLE	Pu	LMOn	ARY	om 9	120	1	2 WOEKS
6	death certificate be executed e attending physician and of for use as the burial-transit	Examiner	Sequentially list conditions, if any, leeding to immediate	C	ue to (or es	e consequ	uence of):				1	
P8/P0	siciar buri	lac	cause. Enter Underlying Ceuse (Diseese or Injury that initiated events	c		Walledon.						
20	ng phy as the	edical	resulting in death) Lest	b	ue to (or es	a consequ	Jence orj:					
ROX	attending	M		d							- 1	
מ	death e atte	SICIB	Pert II. Other significant conditions of	ontributing to death but	not resultin	g in the un	derlying cause gi	iven in Pert I.	23b. Did	tobacco use co	ntribute tr	o the cause of death?
	law requires that the de- as been signed by the a s 2 should be detached to	Physician/							_ 10	Yes 2 No	3 (X Pro	bably 4 Unknown
Ś	igned be de	by	CIMONIC OBS	racino	- /4	-27/1	Unney	111061111				
Hecords,	been signature	pet								an autopsy ormed?	av	Vere autopsy findings
ě.	as by a 2 st	Completed									of	ompletion of cause death?
= (The law	Con							10	Yes 2 No	1[☐ Yes 2☐ No
VITAI	Physicien: The this cartificate ral director, par	Be	25. Wes case referred to medical axaminer?					26. Place of Dea	th (Check only	one)		
0	5 m 6	L _o	1 Yes 2 No	Hospitel: 1 Dinpatien			3LI DON			idence 6 □Oth		ly)
		lon	27. Manner of Deeth 1 ☑Neturel 5 ☐ Pending	28a. Data of Injury (Month, Day	Year) 28	b. Tima of Injury	28c. Inju Wo		280. Describe	how injury occur	red	
SIC	Attending in death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be			do-		Yes 2 No	29f Location	(Street and Numb	har or Due	al Route Number,
DIVISION	2 . 4 .	Certification:	4 ☐ Homicide detarmined	28e. Ptace of Injur building, atc.	(Specify)	, tarm, stre	et, factory, office			wn, State)	AND OF FIGURE	in ricote remoer,
	ours ours filled		29a, Certifier 1 Certifying Ph	sician: To the best of	my knowled	dge, death	occurred at the t	ima, data and place	and due to the	cause(s) and ma	anner as 1	itated.
	24 h Fur letely	edical	(Check only 2 Medical Exam	iner: On the basis of a	xamination	end/or inv	restigation, in my	opinion, deeth occu	rred at the tima	, date and place,	and due to	o the cause(s)
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in b	Me	29b. Signeture end title of certifier	20, 11				se number		29d. Date signe		
	15		Anne a la	m in	0		D 2	-4543		MARCH	t 4,	1999.
	12			-		a) (Type, F	Print)	nio BLUI	., SILV	en spring	5 m) 2090L
	Sta	e	31. Deta filed (Month, Day, Year)						,			
	Registra		WAD 0 5 199	9 Seper	معر	19.	Spark					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death	Reg. No.	08568
Physician	Decedent's Name (First, Middle, Last)	Vee	2. Data of Daath Month Dey Yee	3. Time of Death
Medical	1.10/11/0 7/19,	th Chi Tour cul	march 1 199	2/1/2/
miner	4e Fecility Neme (If not institution, give street end number)	4b. City, Town, or L	200	
,	Montgomery General Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. I	last birthday) If Under 1 Year I If Under 24 Hrs.	8. Date of Birth (Month, Day, Year) 9. B	irthplace (State or Foreign
ral tor	497-20-7535 1□ M 2K F 70	Yrs. Months Deys Hours Min.		Sountry)
	Usuel Residance of Decedant		, , , , , ,	
_	10e. State 10b. County 10c. City	y, Town or Location		10d. Inside City Limits 1 X Yes 2 □ No
ct		kville		
Funeral Director	10e. Street end Number	10f. Zip Code	10g. Citizen of Whet C	
ra	1011 Lewis Avenue	20851	United St	
Ë	11. Marital Status 12. Wes Decedent Ever in U, Armed Forces?	S. 13. Was Decedent of Hispenic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	nerican Indien, nite, etc.
by F	1 Never Married 2 Married 1 Yes 2 M No if Yes, Give 3 Widowed 4 Divorced Year or Detes:	1 ☐ Yes 2 No Specify:	Specify: W	hite
B	15. Decedent's Education	16a. Decedent's Usual Occupation	16b. Kind of Businas	s/Industry
Completed	(Specify only highest grade completed) Elamentary/Secondary (0-12) Collega (1-4or 5+)	(Give kind of work dona during most of work life. DO NOT use retired)	cing	
EO	12	Business Owner	Disaster F	Restoration
Bec	17. Fether's Neme (First, Middle, Last)	18. Mothar's Nam	na (First, Middle, Maiden Sumame)	
10	Frank P. Zeisler	Margare	et McGowan	
	19e. Informent's Name/Ralationship (Type, Print)	19b. Mailing Addrass (Street and Number or Rus		
	Christopher E. Shocklee/Husband	1011 Lewis Avenue, Roc	kville, Maryland	
	20e. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State	Place of Disposition (Name of emetery, crematory or other place) March 6,	Dete 20c. Location - City of	or Town, Stete
	4 Donetion 5 Other (Specify) Gat	e of Heaven Cemetery	Silver Spr	ing, Maryland
any injury or pace.	21. Signeture of Funerel Service Licensee	Robert A. Pumphrey Fune	eral Home/Rockville.	Inc.
2	Konf Fan MO0198			
	23a. Pert1. Entay the diseese, or complications that caused the death shock, or heart failure. List only one ceuse on each line.	n. Do not enter the mode of dying, such es cardiac	or respiretory errest,	Approximate Intervel Between
cian		(- 1 /		Onset end Deeth
lical iner	Immediate Ceuse (Finel disease or condition rasulting in daath)	Concer		2/X WWJPS
		r es e consequenca of):		
Examiner	b			1
Exa	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disaasa or injury c.	r es e consequence of):		
edicai		r es e consequence of):		
	resulting in death) Lest	es e consequence or).		
S	d			
Physician	Part II. Other significent conditions contributing to death but not resu	ulting In the underlying cause given in Pert I.	23b. Did tobecco use contribu	ite to the cause of death?
hy			1 Yes 2 70 3	Probably 4 Unknown
by Physician/				
Completed by			24a. Wes an autopsy performed?	b. Were eutopsy findings eveileble prior to
D e				completion of cause of daeth?
omp			1 Yes 2 No	1 Yes 20 No
Be (25. Was case referred to medical examinar?	26. Placa of Daa	ith (Chack only ona)	
0	Hospital:		ome 5 Rasidance 6 Othar (Sp	pecify)
on:	27. Mannar of Death 1 SNetural 5 Panding (Month, Day Year)	28b. Time of lnjury at Work?	28d. Dascribe how injury occurred	
completely filled in by the funeral Medical Certification: 1	2 Accident Invastigation 3 Suicide 6 Could not be 380 Bloom of Injury. At home	M 1 Yes 2 No		
in of	datarmined 28e. Plece of Injury - At he building, atc. (Specif)	ome, farm, street, fectory, office	28f. Location (Street and Number or City or Town, State)	Hural Houle Number,
edical Certification:	00- 0-4W TD6			
TC 8	(Check only 2 Medical Examiner: On the basis of examinat	wledge, deeth occurred et the time, date end pleca, tion end/or investigation, in my opinion, death occur	, end due to tha cause(s) and mannar rred et tha tima, data and place, and d	es stetad. ua to the causa(s)
Z S	29b. Signature and title of certifie	29c. License number C	29d. Date signed (Mo	onth, Day, Year)
	· 6 1/1 / 101	DO 033666	mil	1999
	20 Name and ottom of A	0 0 000	I will of	11111
	30. Name and address of penden who completed cause of deeth (Item	1 23e) (Type, Print)	all all alla	LF805 ON.
State	31. Dete filed (Month, Day Year) 32. Redistrar's Signal	tura	1 21 0 12	1 2 0 00
egistrar	MAR 04 1999	B. Eparks		



Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Introportant: if Item 27 is marked other than "naturel", or items 23s or 28s-f ahow any Injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requiras that tha death certificate be axecuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completally filled in by the funeral director, page 2 should be detached for use as the bunal-transit

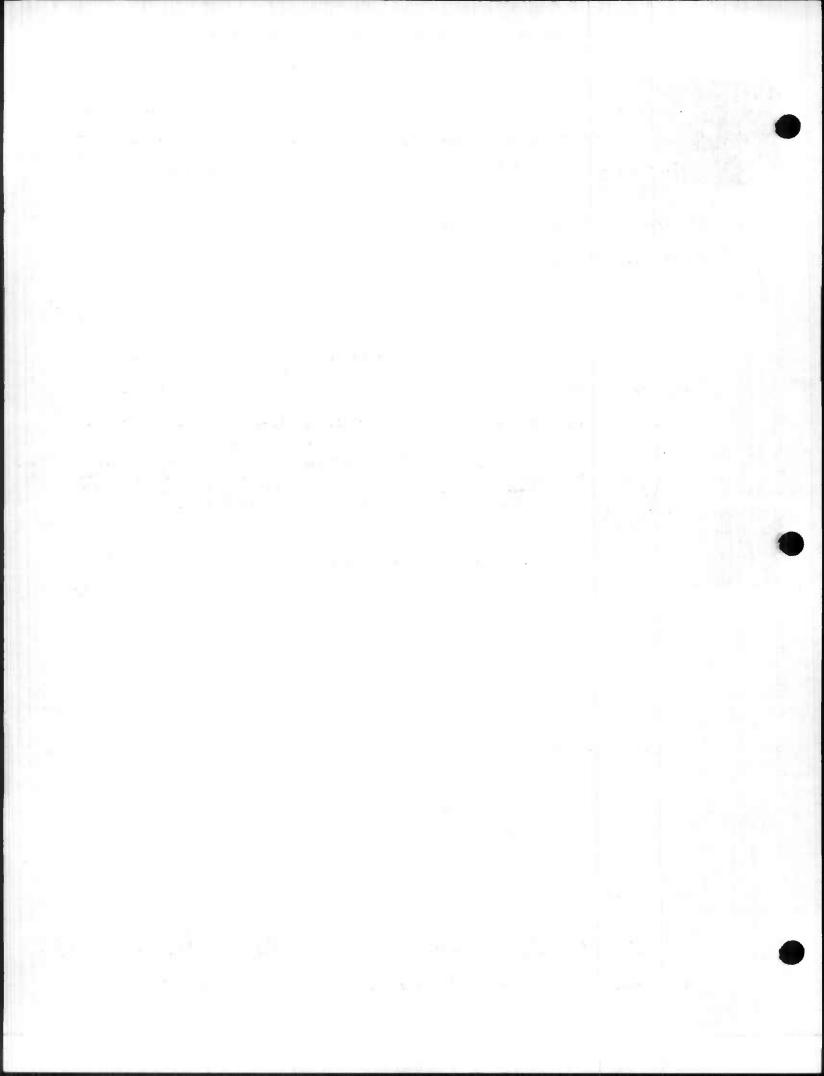
Division of Vital Records, P.O. Box 68760,

			Ce	rtificat	e of	Death			Reg. N	lo.			
1. Decedent's Neme (First, Middle	, Last)										V	3. Tir	ne of Deeth
Chandrawatti S	inghrikh	i										3:	O5 AM
Mary 100 County 100 City, Town or Location 100 Feels City 100 Fe		J W ANA											
-											ntgor	mer	У
5. Social Security Number 214-02-4443								8. Dete of Bid (Month, De May 2	th by, Yea 19	r) 24			
Usuel Residence of Decedent													
30 31=1											1		-
	omery	Ga	nither									- 11	100 2
									10g. C			ntry?	
		adant Ever In 11	C 40			liana ala Oa	i-i-0 (C-					an India	
	Armed F	orces?	, 5. 15.	If Yes, spe	cify Cub	en, Mexica	n, Puerto	Rican, etc.))-				gt1,
	If Yes, G	ive **		1 🗆 Yes	2⊠ No	Specify.				Specif	y: Eas	st I	ndian
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Elementery/Secondary (0-12)	1		life.	DO NOT u	se retire	d)				0	TT		
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20e. Method of Disposition	,	120											
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21. Signature of Funeral Service L	icanseo							ert A.					
1 the	1-11-	1	Ro	ckvil	lle,	Inc.	300	West M	ont	gome:	ry Av	enue	e,
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23a han talure. List o	only one ceuse on	eech iine.	n. Do not en	ter the mod	ie or ayır	ng, such es	cardiac (or respiretory e	rrest,		\$ 	Interve	Between
Immediate Cause /Final											1	Onadi	and Death
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resulting in deetn)	Acute	Due to (o	r es e conse	quenca of):	CCIO	11					i		
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	d												
Pert II. Other eignificant condition	ne contributing to d	leeth but not resi	ulting in the u	nderlying o	ause giv	en in Pert	l.	23b. Did	tobacc	o uee co	ntribute to	the ca	use of death
HTN								1 🗆	Yes	2□ No	3 Prot	pably	4₽ Unknow
								24a Was	en eu	ODEV	24h W	ere auto	nsy findings
Diabetes Mell	itus										ave	eilable p	prior to
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25. Wes case referred to medical						26. Plec	e of Deetl	h (Check only	one)				
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27. Menner of Death	28e. Dete	of Injury	28b. Time o					-					
		nn, Dey Tear)	Injury				No						
3 ☐ Suicide 6 ☐ Could no	ot be	a of Injury - At he	ome, ferm. str	reet, factor				28f. Location /	Street	end Numi	per or Rura	l Route	Number.
4 Homicide	build	ling, etc. (Specif)	y)	,	,,							- 3.9	
29e. Certifier Certifying	Physicien: To the	best of my know	wiedge, deetl	h occurred	et the tir	ne, dete er	nd plece,	end due to the	cause	s) end ma	anner as si	eted.	uea(e)
one)	xammer. On the D	esis of exemine	non author in	vestigetion	, in my o	pinion, dea	un occurr	eu et tile time,	dete e	na piece,	and due to	tue cer	
29b. Signeture and title of cartifier	Ť		0	290	c. Licens				29d. D	ete signe	d (Month,	Day, Ya	ar)
Kuth	Han	a Mel	1).		V	519	PO		M	and	109	10	299
30. Neme end eddress of person w	ho completed carr	se of death (Item	23e) (Type	Print)	-	- (,	0		1-6	
Brett Gamma, M.					u e	Pooles	411 _~	Mass	an-	200	50		
31. Dete filed (Month, Dey, Year)		Registrer's Signa		DIT	v C ,	ROCKV	ттте	, mary.	LaliC	200	0		
////		/	KA			/ /							

32. Registrer's Signature

MAR 0 5 1999

State Registrar

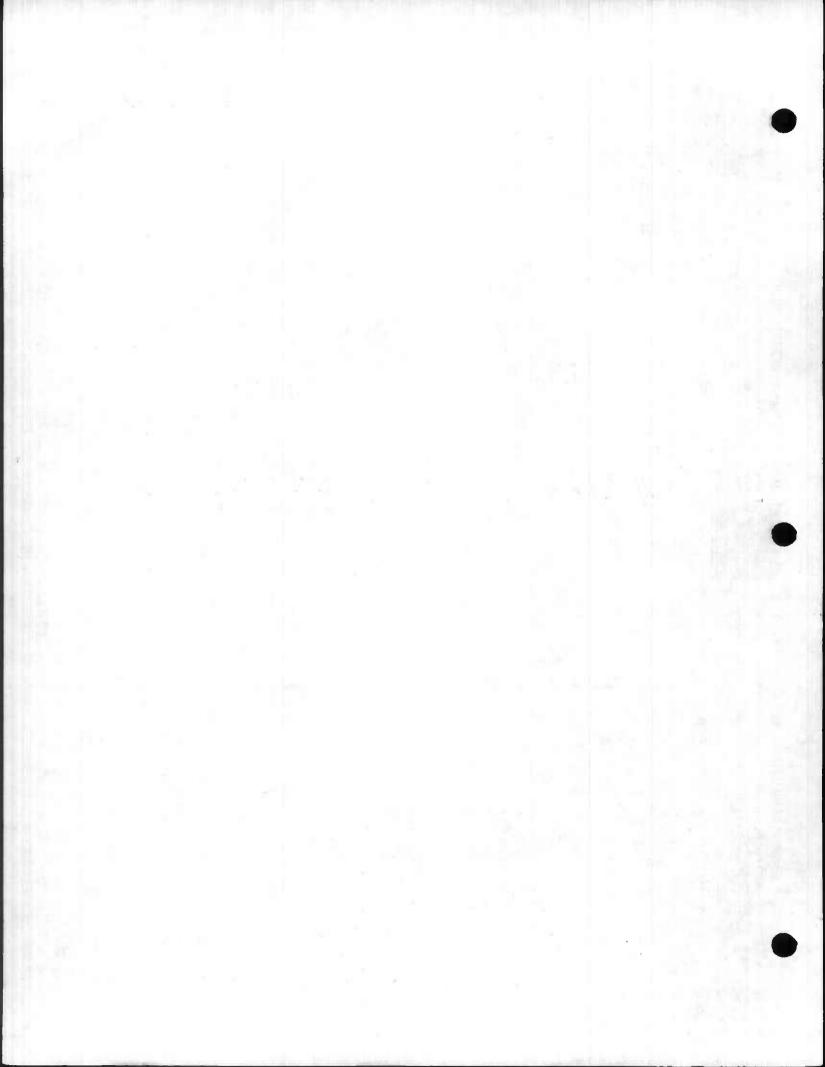


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** February 25, 1999 Edward Kershaw Smith 4:05 PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

April 12, 1922 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 101M 2□ F Months 76 Yrs. 066-12-0922 Director New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygione. Important: If item 27 is marked other than "natural", or itema 23s or 28s-f show any injury or other traumatic avant, the Medical Examine must be normed and once. 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No Director Maryland Montgomery Bethesda 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code 7608 Shadywood Road 20817 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian. Black, White, etc. 1 ☐ Never Married 2 Married Baltlmore, Maryland 21215-0020 ff Yes, Giva Year or Dates: WW II 1 ☐ Yas 2 ☒ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Economist United States Government 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be Helen Baro Clifford Kershaw Smith 2 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) James Edward Smith/Son 7500 Woodmont Avenue #522, Bethesda, Maryland 20814 20b. Place of Disposition (Nama of cometary, crematory or other place) February 2 Pate 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, M00846 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 int caused the cleath. Do not enter the mode of dying, such as cardiac or raspiratory arrast, on each line. Approximata Interval Batween Onset and Daath **Physician** /Medical Immediata Causa (Final diseasa or condition rasulting in death) week Examiner Examine attending physician and for use as the burlal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medical that initiated events resulting in death) Last Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in tha underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings availabla prior to complation of cause of death? Be Completed 24a. Was an autopsy 1 Yes 2 1 No 1 ☐ Yas 2 No 25. Was case referred to medical 26. Placa of Death (Check only one) Hospitat: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1/2 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Dascribe how injury occurred 28c. Injury at Work? I or Attending F 5 Pending investigation 1 Natural 1 Yes 2 No 2 ☐ Accident Diractor: 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicide 6 ☐ Could not be 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital c within 24 hours at To the Funeral D completely filled Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and dua to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. Medical 29a, Certifier 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifie 29c. License number 3041 eted cause of death (Item 23a) (Type, Print) p or stute 212 diney MD 20832 Mengl 811 Vrinco ralle 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 0 2 1999 severa Registra

edward K.



State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Deeth 3. Time of Death Month February 1999 12:30pm 27 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death 13015 Broadmore Road Silver Spring Montgomery If Under 1 Year | If Undar 24 Hrs. | 8. Data of Birth (Month, Day, Year) 7. Age (in yrs. lest birthday) Birthplace (Stete or Foreign Country) Days Hours Yrs. 65 July 11,1933 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No Silver Spring 10f. Zip Code 10g. Citizen of Whet Country? 20904 United States

Funeral Director

Physician

/Medical

Examiner

Vera Carmela

Pages 1 and 2 should be filed within 72 hours after death with the Manyland neat of Heatih and Mental hygiene. In merked other than "netural", or fleme 23a or 23a-f ahow int: If file 27 I a marked other than "netural", or fleme 23a or 23a-f ahow uny or other traumatic avent, the Medical Example must be notified at

permit. Page Department of Important: If any injury or **Physician** /Medical Examiner

Baltimore, Maryland 21215-0020

physician end the buriel-transit lew requires that the death certificate be executed ettending pi for use as t signed by the eld be detached for s certificate hes t director, pege 2 s The this

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: funeral director, After death. efter death Director: in by To the Hospital or within 24 hours eft To the Funeral Di completely filled in

5. Social Security Number 1□M 2\ F 578-44-9789 Washington D.C Usuel Residence of Decedent 10e. State 10b. County Director Md. Montgomery 10e. Street and Number 13015 Broadmore Road Funeral 12. Was Decedant Evar in U,S. Armed Forcas?

1 Yes, 2 No If Yes, Giva Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, atc. 1 ☐ Nevar Married 2 ☐ Merried 1 ☐ Yes 2 No Specify: White by 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education 16e. Decedant's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surnema) 17. Fether's Neme (First, Middle, Last) Angelo Dante Serio Lena Rivers Guy 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. informent's Name/Ralationship (Typa, Print) 17001 Downing St. #301 Gaithersburg, Md. 20877 Patti S. Smith (Daughter) 20b. Place of Disposition (Name of cometery, cromatory or other place)
Gate of Heaven 20e. Method of Disposition Dete 20c. Location - City or Town, Stete Mar. 3. 1 N Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete Silver Spring, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 1999 21. Signature of Funerel Service Licent 22. Nema end Addrass of Facility DeVol Funeral Home Curles 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each lina. Approximate Intarvel Between Onset and Death Immediate Cause (Final disaase or condition rasulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Causa (Diseese or Injury that Initiated events resulting in death) Lest Due to (or es e consequence of) Physician/Medicai Due to (or es a consequenca of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown thursidism þ 24b. Wera eutopsy findings eveileble prior to completion of cause of death? Completed 24e. Wes en eutopsy 1 Tes 2 No 1 Yas 2 No Be 25. Was casa rafarred to medical exeminer? 26. Plece of Deeth (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1X Yes 2□ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Yeer) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Naturel 5 Panding 1 Yes 2 No 2 Accidant investigation 6 Could not be detarmined 3 Suicide 28f. Location (Straat end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Spacify) 4 Homicide 15 Certifying Physician: To the bast of my knowladge, daath occurred at tha tima, data and place, end dua to the ceuse(s) and mannar as stated.
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, daath occurred at the time, deta and place, and due to the cause(s) end manner stated. 29a. Cartifian edicai

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32. Registrar's Signature

29d. Date signed (Month, Day, Year)

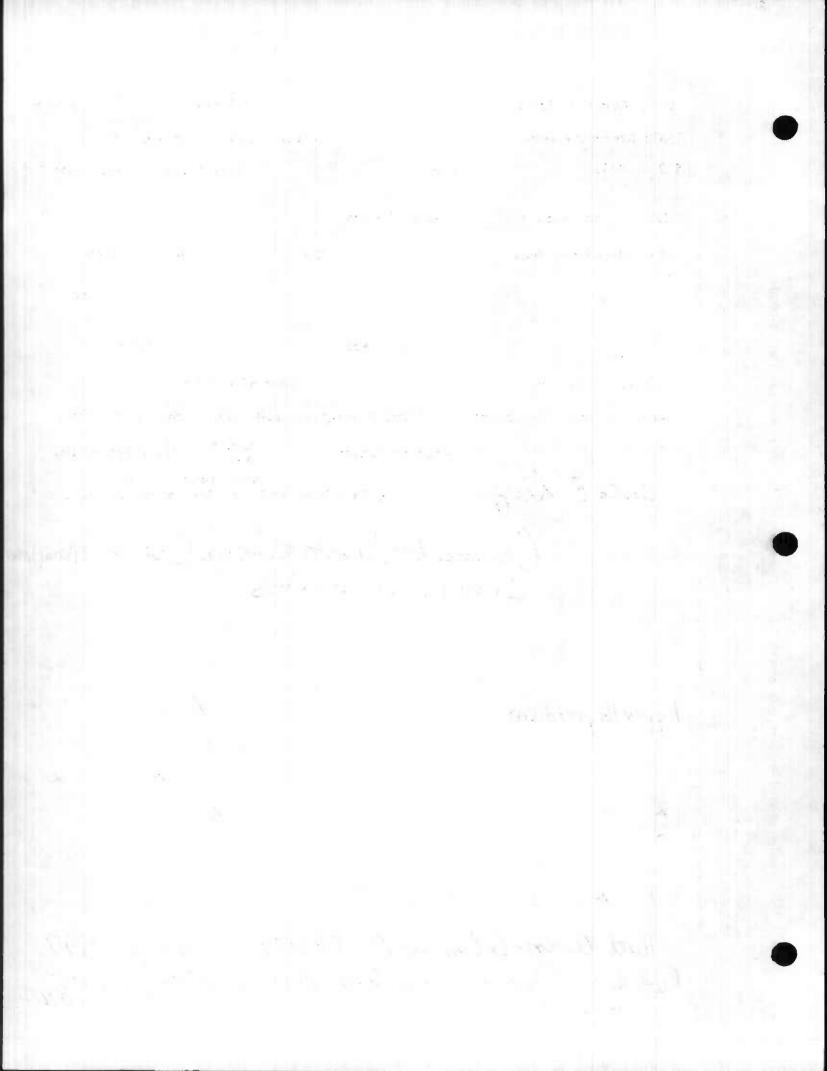
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29b. Signeture end title of certifier

31. Date filed (Month, Day, Year)

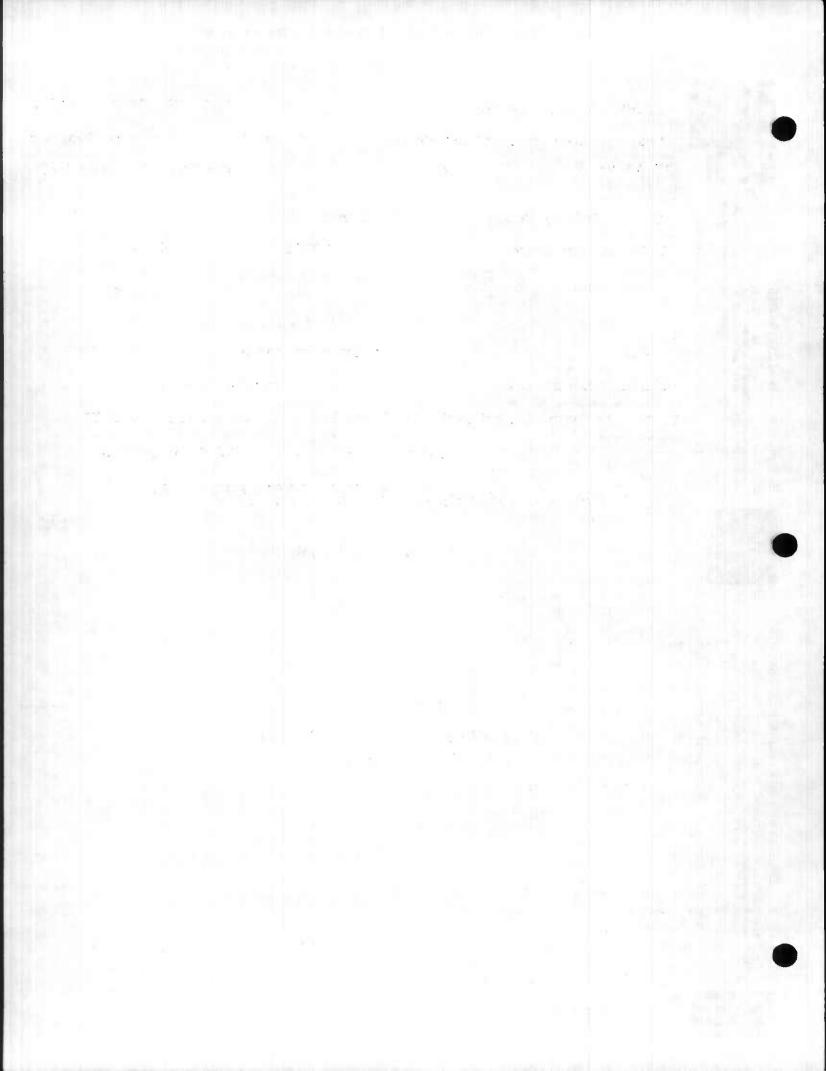
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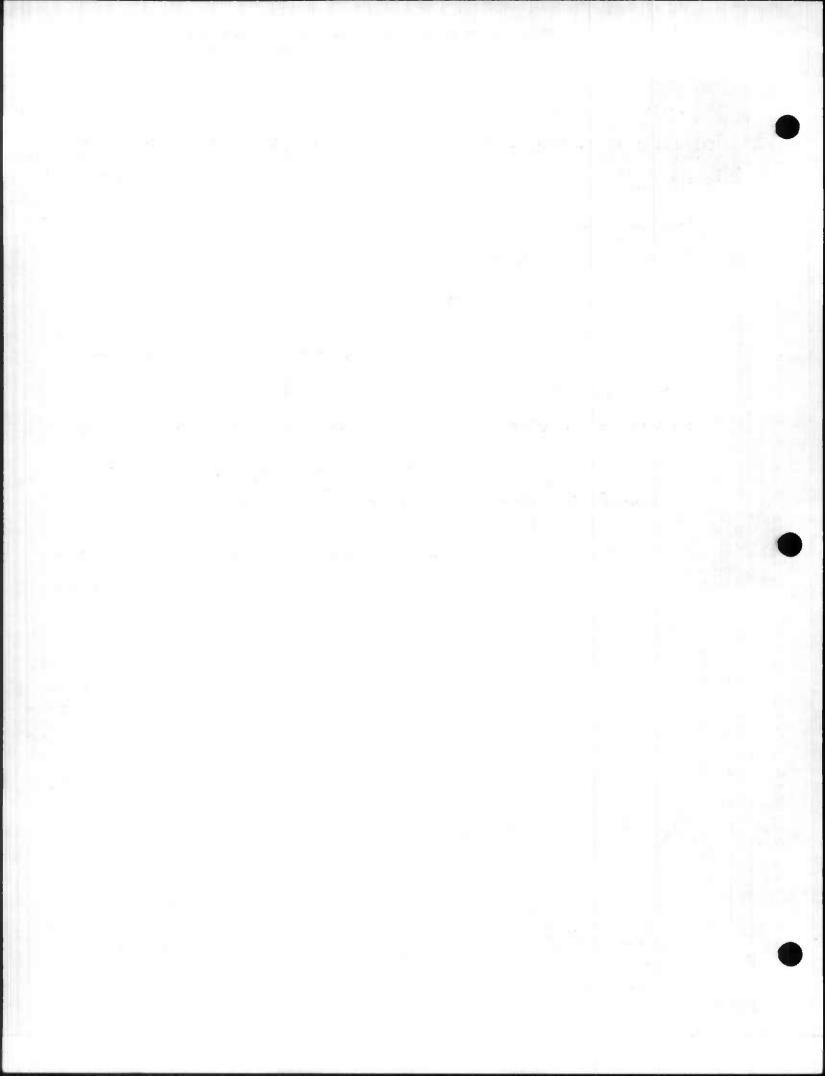
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	11. Maritel Status 12. Was Decedent Ever in U,S. 13. Was Decedent of Hispanic Origin? Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuben, Mexican, Pu	3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1□ Yes 2□ No Specify: 1□ Yes 2□ No Specify: 12. Race - American Indien, Black, White, etc. Specify: Black		14. Race - American Indien, Biack, White, etc.	
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pemit. Peges 1 en Department of Heal Important: If Item 2 Important: If Item 2 Important: other			na Powell		
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19cree Melvern (Daughter) 7801 Mandan Rd., Greenbelt, MD 20770				
	20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place)	Date	20c. Location - City or T		
	Maurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) **Description Daisy Church Cem.	3/3/99	Woodbine	, MD	
	21. Signature of Funeral Service Licenses 22. Name end Address of Facility				
	SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850				
	23a. Part 1. Enter the disase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fire yre. List only one ceuse on each line. Approximate Interval Between			Approximate Interval Between	
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5	30 Name and address of parent who completed cause of death (Item 23a) (Tune Brist)				
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Registrar



State of Maryland / Department of Health and Mental Hygiene O O

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		State of Maryla			rtment of		Mental Hy	rgiene g	0	8574
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	111 to prono	un -	21	20	00 S. H	ARRISON ST	. EAST	ON, MD 2		
	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused tha di ne ceuse on each line.	eath. Do i	not ente	er the mode of d	rying, such as cardie	c or respiretory a	arrest,		Approximete Interval Between Onset and Death
Physician /Medical	Immediate Cause (Final	1/2/	1 1.		11					. 1
Examiner	disaase or condition resulting in death)	Metast	who	<u></u>	Hall	nocar	unor	na		nontro
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be executed sician and bunel-transit		b	/or oc o	000000	uence of):					
be executed ician and buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D04 (C	(OI as a C	conseq	dende oij.					
sicia por	Cause (Disease or injury that Initiated events	Due to	(or as a c	conseq	uance of):					
	resulting in death) Last		(0. 40 4 6							
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requires that the death cartifica been signed by the ettending phenould be detached for use as the eted by Physician/Med	Part II. Other significant conditions cor	ntributing to deeth but not i	esulting in	n the ur	nderlying cause	given in Pert I.	23b. Did	tobecco uee co	ntribute to	the cause of death?
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hes be ge 2 sh mple										nplation of causa leath?
The law ete hes to page 2 s							10	Yes No	10	Yas 2□ No
yaician: The s certificate director, par	25. Was case referred to medical examiner?						eth (Check only	one)		
T dis	1 Ves 2√No	lospital: 1 Inpatiant	DER/OU	utpatien	I BLI DOA			idenca 6 🗆 Oth)
ng Ph fter th uneral	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of injury (Month, Day Year	28b. 1	Time of Injury		njury at Work?	28d. Describe	how injury occur	red	
eath. or: A the fu	2 Accident investigation 3 Suicida 6 Could not be					Yes 2 No				
or Att	4 Homicide determined	28e. Plece of injury - A building, etc. (Spe	t homa, fa	ırm, str	eat, factory, offi	ce	City or To	(Straet and Numb own, Stete)	oer or Hura	Houte Number,
oftal ours a control of tal of	00.0.45			1						
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th complataly filled in by the funeral Medical Certification:	29a. Certifier 1 Certifying Physical Check only one) Medical Exami	ner: On the best of my lener: On the basis of exam and manner stated.	nowledge ination an	death dor inv	occurred at the restigation, in m	time, dete end place y opinion, death occ	e, and due to the urred at the time	cause(s) and mand the date and place,	anner es st and due to	the cause(s)
ithin of the complex Med	29b. Signeture and title of certifier	and mailler stated.		-	29c. Lic	ense number		29d. Date signe	d (Month, L	Dey, Year)
F3F8	Corola	Holmel	MI	>	D5.	3602		3/1	199	
	30. Name and address of person who co	molecular of deal	tom 22a)	(Time		7002		0/7/	//	
	CAROLYN HELMLY,					, EASTON,	MD 2160	1		

B. Spark

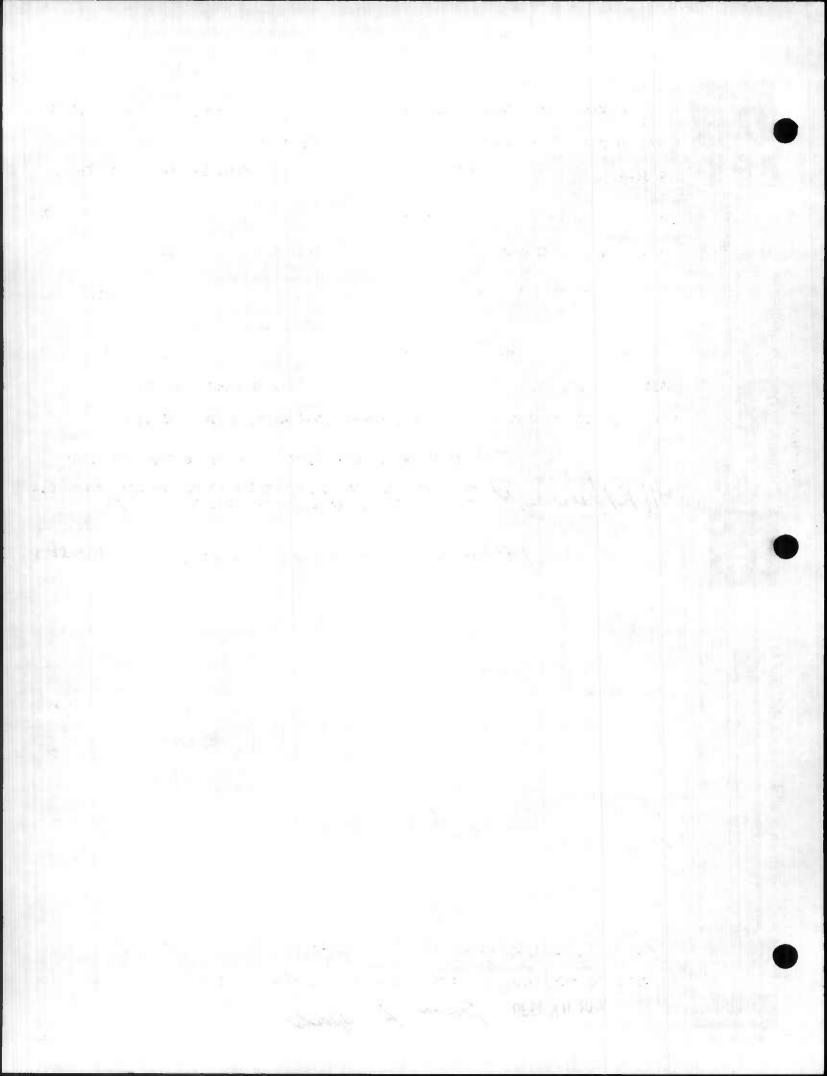
DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month MAR 0 5 1999 32. Registrer's Signatura

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

George Short



State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** SCARFF RUTH BUSLER MARCH 2, 1999 11:51 /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Saint Joseph Medical Center Towson Baltimore 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 10/10/1921 5. Sociel Security Number Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F Maryland 215-18-3173 Director Usuel Residence of Decedent with the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examinar must be notified at 1 Yes 2 No Fallston Director Md. Harford . 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21047 U.S.A. 3234 Charles Street Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 11. Meritel Status 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or ite 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Caucasian þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) Payroll Clerk Pharmaceuticals 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Garfield Busler Elizabeth Helen Winskowski Joshua 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 Ia m E. Nelson Scarff/Husband same as #10 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 3/6 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State ò 4 ☐ Donetion 5 ☐ Other (Specify) 1999 any Injury Ebenezer Cemetery Fallston, Maryland 21. Signeture of Funerel Service Licepsee 22. Name and Address of Fecility E.G. Kurtz & Son Funeral Home, P.A. 23a. Pert1. Enter the disease, or complications that card of the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Jarrettsville, Maryland Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical MULTIPLE MYELOMAS 6 MONTHS Examiner Due to (or es e consequença of) Examiner attending physicien and for use as the bunel-transit requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of) Box 68760. Physician/Medicai the Due to (or es e consequenca of): use as I ō Pert il. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? he 5 1 Yes 2 No 3 Probably 4 Unknown END-STAGE RENAL DISEASE Division of Vital Records, þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? SEVERE PANCYTOPENIA hes 1 ☐ Yes 2 No 1 Yes 2 No certificate 25. Wes case referred to medical exeminer? director, Be 26. Piece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this funerel 27. Manner of Deeth 28b. Time of 28e. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 28c. Injury et Work? of or Attending Patter of Director: After 1 Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated. 29e. Certifier Medicai completely (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D19508 de m.5. mach 2, 1999 30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) DELEON, NATIVIDAD D. M. D. 7601 OSLER DRIVE. TOWSON, MARYLAND 21204 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State MAR 1 0 1999 Registrar

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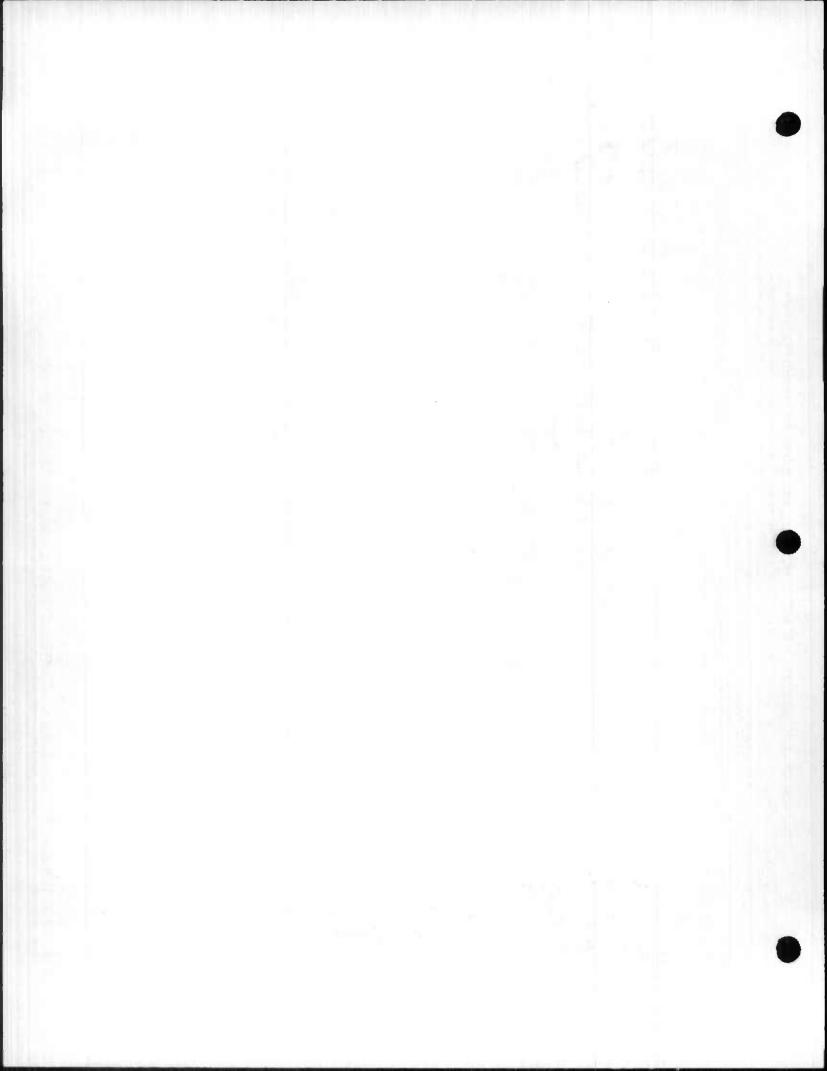
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DIVISION OF VITAL RECORDS, P.O. BOX 13146,

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. OECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH MONTH, DAY YEAR 3. TIME OF DEATH														
	Roy Fran		nyder							March	I	" 1	953	10:30PM M	
	4. SOCIAL SECURITY NUME 217-16-2405	BER	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER	1 YEAR DAYS	IF UNDE	R 24 HRS. MIN.	7. DATE OF (Month, De Sept.	BIRTH By, Year)	1913	Countr	PLACE (State or Foreign y) Yland	
	90. FACILITY NAME (If not in	astitution give a				9h CITY	TOWN (OR LOCAT	ION OF D	_	25,		NTY OF D	-	
OR	4 N. Second	d St.						boro					eder		
5	RESIDENCE OF DEC	10b. COUNT	v		10c CIT	Y, TOWN C	B LOCA	CION						10d. INSIDE CITY	
E I	Maryland		rederick		100. 01		odsb						LIMITS?		
_	10e. STREET AND NUMBER		rederiek			1100		. ZIP COD	DE	10g. CITIZEN			ZEN OF V	F WHAT COUNTRY?	
ERA	4 N. Secon	nd St.			21798							U.S.			
BY FUNERAL DIRECTOR	11. MARITAL STATUS 1 Never Married 2 🔀 3 Widowed 4 Divo		FORCES?	NT EVER IN U.S. AR 1 X YES 2 P WAR OR DATES 1941	NO		f yee, sp	ecify Cub	OF HISPAI an, Mexico Specif	an Puerto Bican, etc.)			Blaci	— American Indian, K, White, etc. White	
-		EDENT'S EDU		16a, DE	CEDENT'S	USUAL O	CCUPATION	ON		16b. KII	ND OF BU	SINESS/INC			
COMPLETED	(Specify onli Elementary/Secondary (I	ly highest grade 0-12)	College (1-4 or 8	+) (G	. Do NOT u	work done (se retired.)	during mo	ist of work	ing						
AP I	11		4		supervisor				n	naint	enan	ce			
S	17. FATHER'S NAME (First, M					18. MOTHER'S NAME (First, Mic									
BE (Roy David					_	Eliza		0						
70	Juanita R. S							Route Number, Sboro,			,				
	20e. METHOD OF DISPOSIT 1 Buriel 2 Crematic 4 Donation 6 Other	on 3 🗆 Rem	noval from State	adhar at	PLACE OF DISPOSITION (Name of cometery, cremetory or other place) Ountain View Cemetery 3/4/99 Union Bridge										
	21. SIGNATURE OF FUNERA		CENSEE		Lain										
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Hartzler Funeral Ho 404 S. Main St. Woodsboro, MD 21														
CERTIFICATION	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury														
ERTI	that initiated events resulting in death) LAST														
MEDICAL C	PART II. Other significant conditions contributing to death but not resulting						nderlyln	g cause	given in		PERFO	-	248	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
_														1 TES 2 NO	
IAI	25. WAS CASE REFERRED T	TO MEDICAL	Hoosies					LACE OF	DEATH (C	heck only one)					
SIC	1 TES 2 THO		HOSPITAL:	☐ ER/Outpetient 3	3 🗆 DOA	4 - Nu		no 6 12 1	Residence	6 🗆 Other (S	Specify)				
PHYSICIAN:	27. MANNER OF DEATH 1 Neture: 6	Pending	28a. DATE C (Month,	F INJURY Day, Year)	28b. TH	ME OF JURY M	W	JURY AT ORK? YES 2	□ NO	28d. DESCR	NBE HOW	INJURY OC	CURED		
TED BY	2 Accident 3 Suicide 6 4 Homicide	Could not be determined	OF INJURY At he	M 1 YES 2 NO INJURY — At home, farm, street, factory, office c. (Specify)						ON (Street Town, State		r or Rural	Route Number,		
COMPLET	one)		SICIAN: To the best ER: On the beste of											a) and manner as stated.	
	296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICES									MBER		29d. DA	TE SIGNE	D (Month, Day, Year)	
38 C	Im A- Figell, m.D. DO								D0016637 > 3/2/99						
5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James A. Frizzell M.D. 915 Toy House Ave. # 201 Frederick, MD 21701														
	31. DATE FILED (Month, Day,	0 4 199		AR'S SIGNATURE	B.		out							, , , , , , , , , , , , , , , , , , , ,	



hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

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ysician and completely filled in by the prior to burial, cremation, or removal,

the attending physician I Mental Hygiene prior to

been signed by the pt. of Health and N

Dept. (

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DIRECTOR: After the hours after death with them 28 is mark

TO THE HOSPITAL OF THE FUNERAL D BE filed within 72 ho

BOX 6876 P.0. DIVISION OF VITAL RECORDS,

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be

99 08577 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME /First Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH March Eva M. Stonesifer
4. SOCIAL SECURITY NUMBER 5 1994 11:15A. м 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 6. BIRTHPLACE (State or Foreign Country) 199-07-3492 DAYS HOURS 1 M 2 FF April PA Se. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Carroll 1038 Cherrytown Road Westminster RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION Westminster 10d. INSIDE CITY 10e. STATE Carroll 1 YES 2 NO 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? USA 1038 Cherrytown Rd. 21158 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: FORCES? 1 YES 1 Never Merried 2 Merried 2 6400 IF YES, GIVE WAR OR DATES White 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY El@nentary/Secondary (0-12) College (1-4 or 5 +) Housewife Housework 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle Meiden Surneme) Claude Kessler Lizzie Becker 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Stonesifer In-law 6514 Monroe Ave. Sykesville. MD 21784 20e. METHOD OF DISPOSITION
1 Burlet 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION / Name of 20c. LOCATION — City or Town, State DATE vergreen Memorial Gardens 3/5/99 Finksburg, MD21048 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Little'sF.H.34 Maple Ave.Littlestown,PA17340 23. PART I. Enter the diseasee, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Desth IMMEDIATE CAUSE (Final disesse or condition aunectic Caucer resulting in desth) DUE TO (OR AS A CONSEQUENCE OF): Sequentisity list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate Cause Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in desth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN M 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)

COMPLETION OF CAUSE 1 TYES 2 NO OF DEATH? 1 TYES 2 NO

HOSPITAL: OTHER: 1 YES 2 AO 1 | Inpatient 2 | ER/Outpetient 3 | DOA ng Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 26s. DATE OF INJURY 26c. INJURY AT WORK? 26b. TIME OF INJURY 26d, DESCRIBE HOW INJURY OCCURED 5 Pending Investigation 1 Natural 1 YES 2 NO

2 Accident 26e. PLACE OF INJURY — At home, farm, street, fectory, offica building, atc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 4 Homicide

29e. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) end manner as stated. 2 _ MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) and manner ee stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Mo.
Mullo	42254072	D =60 1

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAL

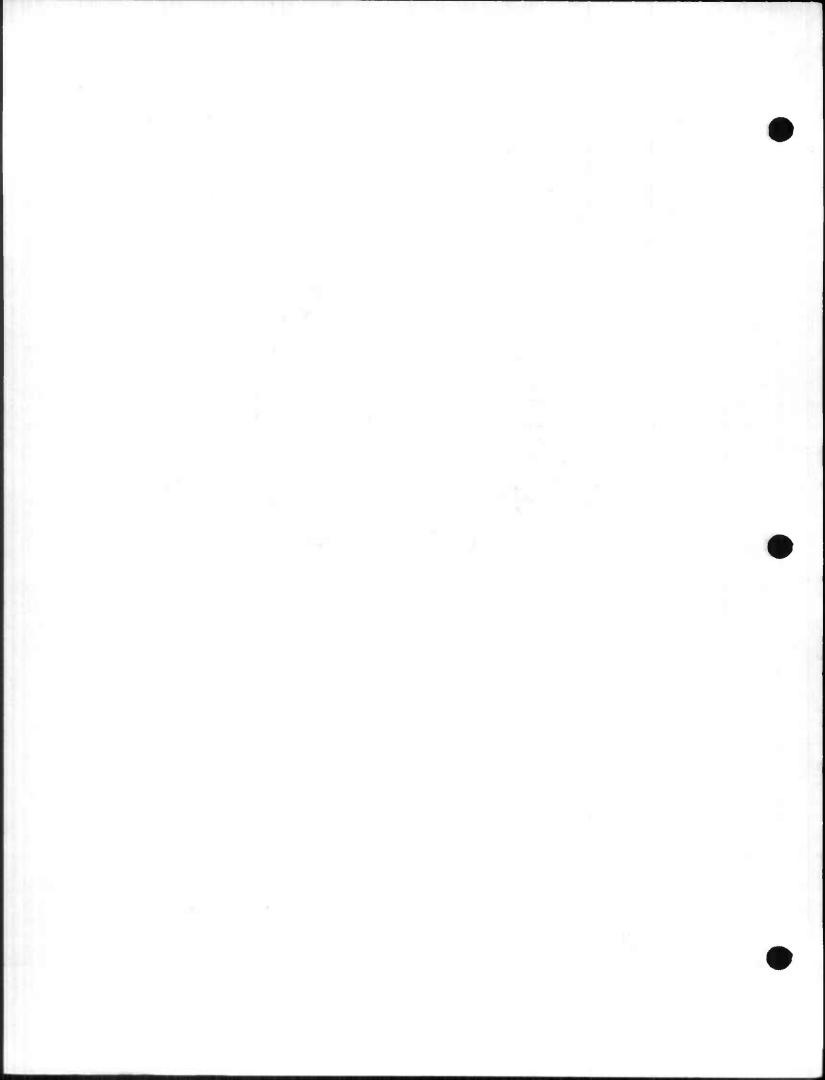
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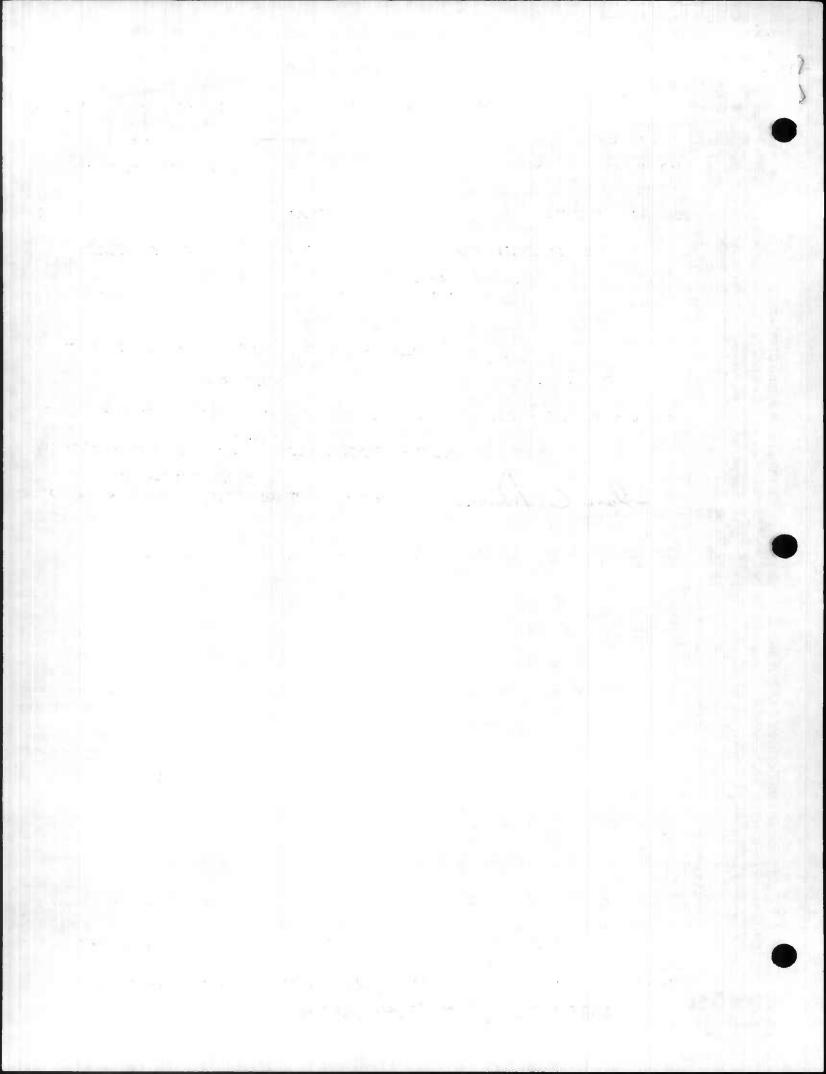
32. REGISTHAR'S SIGNATURE 31. DATE FILED (Month, Day, Year) MAR 0 4 1999

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nth, Day, Year)



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Director	Usuel Resident 10e. State MARYLAN	10b. County	OLL	7	10c. Ci	ty, Town o	or Location	KE	YMAR				1	0d. Inside City Lin
	10e. Street end		BRUCE	VILLE R	OAD		10f. 2	Zip Code	21757	- 10			Vhet Cour	
Dy Laileian		tus Married 2 X Marr ed 4 Divorced	ied	Was Decedent Armed Forces? 1 XYes 2 I If Yes, Give Yeer or Detes:	No 19	43- 45		cedent of Hoecify Cubo	lispenic Origin? an, Mexican, Pue Specify:	Specify Yes o			k, White,	
		15. Decedent Specify only highes	t's Education	on		10	ecedent's Us	work done	during most of w	orking	16b. Kl	Ind of Bu	siness/In	dustry
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To Be C	17. Fether's Ne	william William		ELY						JDE OTT	O.			
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		2 Cremetion		ovel from State	20b.	Place of D cemetery UGH'S	isposition (A cremetory of CHUR	leme of rother pla CH CE	METERY	MARate1,				own, State MARYLANI
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death ^{Day}1999 **Physician** Month WILLIAM FRANCIS SHARPLESS, SR. March 1, 0920 AM /Medical 4e. Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 11834 EDGEHILL TERRACE PRINCESS ANNE SOMERSET If Undar 1 Yaer If Under 24 Hrs. 8. Date of Birth (Month, Day, Yaar) 5. Social Security Number Sex 1₽M 2□ F 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Months Deys Yrs. Director 217-28-3073 June 29, 1931 Pennsylvania Usual Rasidance of Decedant the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumetic event, tra Medical Examinar must be notified at 1 Yas 2 No Directo Maryland Somerset Princess Anne 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 11834 EDGEHILL TERRACE 21853 death Funeral U.S. 12. Was Decedant Evar In U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puarto Rican, atc.) Race - Amarican Indian, Black, White, etc. 1 Yas 2 No If Yas, Giva Yeer or Datas: 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: þ Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed within 7 Depertment of Health and Mental Hygiene. Important: if item 27 is merked other than "n any Injury or other traumatic event." Elamantary/Secondary (0-12) Collaga (1-4or 5+) **DUPONT INDUSTRIES** PANEL BOARD OPERATOR 12 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) NORMAN A. SHARPLESS, SR. ELSIE SMITH 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) MRS. ROSE P. SHARPLESS 11834 EDGEHILL TERRACE, PRINCESS ANNE, MD. 21853 20e. Mathed of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stete 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) 03/04/99 PR. ANNE, MD. BEECHWOOD CEMETERY 21. Signature of Funaral Service Licensee 22. Nama and Addrass of Fecility HINMAN FUNERAL HOME, P.A.

11673 SOMERSET AVE, PRINCESS ANNE, MD. 21853

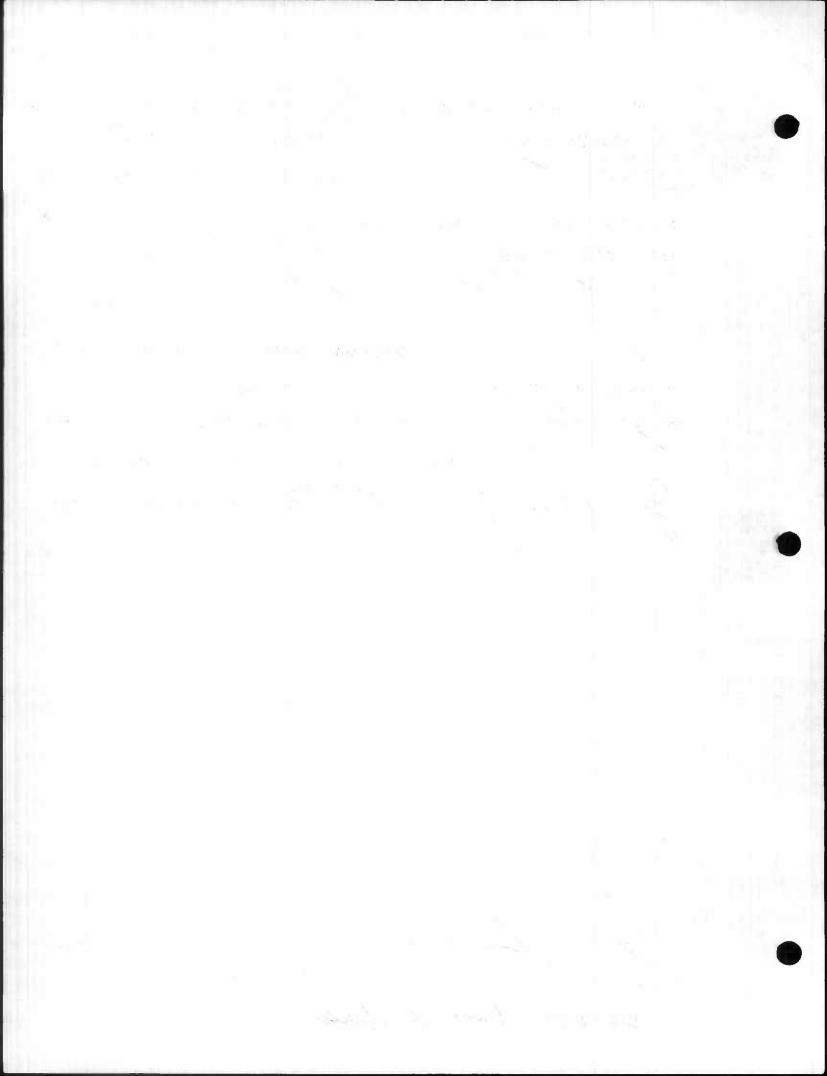
23 Porti. Enter the disease, or complications that can ad the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest,

Approximate Approximate Interval Batween Onsat and Death **Physician** Motestatic Adeno carcinona, Unknown

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Primary Origin /Medical Immadiata Causa (Final 18 months disaasa or condition rasulting in daath) Examiner Examiner the buriel-transit be executed Sequantially list conditions, if eny, leading to Immadiata causa. Enter Undarlying Causa (Disaasa or Injury that Initiated avants rasulting in death) Last Dua to (or as a consequence of): Box 68760. physician Physician/Medical Dua to (or as a consequence of): for u P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Records, by 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Wes an autopsy performed? Completed certificate hes 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital To the Hospital or Attending Physicien: within 24 hours efter deeth.

To the Funeral Director: After this certification properties of the funeral director, it is the funeral director, it is the funeral director, it is the funeral director, it is the funeral director, it is the funeral director, it is the funeral director. 25. Was casa rafarred to madical Be 26. Place of Daath (Check only ona) Other: 4 Nursing Home 5 Nasidance 6 Other (Specify) 70 1 Yas 2 XXX 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Data of tnjury (Month, Day Year) 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury at Work? ↑ Ratural 5 Panding investigation 1 Yas 2 No 2 Accidant 3 Suicida 6 Could not ba datarmined Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Numbar, City or Town, Stata) 4 Homicida 12 Certifying Phyelcian: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Cartifian (Check only 29b. Signature and tyle of certifiar 29c. Licansa number 29d. Dete signed (Month, Day, Year) 1.0 030690 30. Nama and addrass of parson who implated causa of death (Itam 23a) (Type, Print) 145 E. Grand St., 5-1.5 bury, MD. Martin M.O. E. James 31. Dete filad (Month, Day, Year) 32. Ragistrar's Signature State Registrar MAR - 3 1999



Amended linel, FCHD, KS

Please

Type or Print in Black indelible ink. Assure			
State of Maryland / Department of Health and	Mental Hygiene	1	8580
Certificate of Death	Reg. No.		
U	2. Date of Death Month Day	Year	3. Time of D

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

	1. Decedent's Name (First, Middle,	Last)	The second					2. Date of D			3. Time of Death	
Physician	John Oggen Stee							March	Day 4 10	Year	10:44 P.M	
/Medical Examiner	4a Facility Name (If not institution, g		or)				4b. City, Town, o	or Location of Dea		999 y of Death		
Examine	Frederick Memor	ial Hospit	al				Frederi	cb	k Frederi		b	
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r flems 23sh niner must	11. Marital Status	12. Was Decedar		13. W	as Deceder	nt of F	Hispanic Origin? (Specify Yes or No- 14. R			ce - Americ	can Indian,	
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d other went,	17. Father's Name (First, Middle, Last)						18. Mothar's N	ama (First, Midd	la, Maiden Suma	m <i>e)</i>		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Insportant: If item 27 is marked other than "natural; or item 27 is marked other than "natural; or other traumatic event, the Medical Ensirinar must be notified an ance. To Be Completed by Funeral Director	Lloyd (NMN) Sto	rel					Bertha	Rebecc	a Oader	n.		
	19a. Informant's Name/Relationship		190	b. Malling	Address (Street			0		Code)	
end 2 eaith a n 27 is	19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia W. Serkiz / niece 243 Diamond Ave., Walkersville, MD 21793											
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	resulting in death)		Due to (or as a	consequ	uenca of):			141111			1	
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tal or Attending P rs efter death. al Director: After t led in by the funer: Certification:	4 Homicide determine	200. Place of	njury - At home, fa etc. (Specify)	arm, stre	et, tactory, o	OTTICE		City or 7	(Street and Num own, State)	iver or Hura	u rioule Number,	
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To the Hospital or Attending Physician: White 24 hours effected: After this certific completely filled in by the funeral director, Medical Certification: To Be (29a. Cartifier 29a. Cartifier (Check only Check only 2 Medical Examiner: On the basis of examination and/or investigation. In my online, data and place, and due to the cause(s) and mannar as stated.											
the F	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the causa(s) and manner stated											
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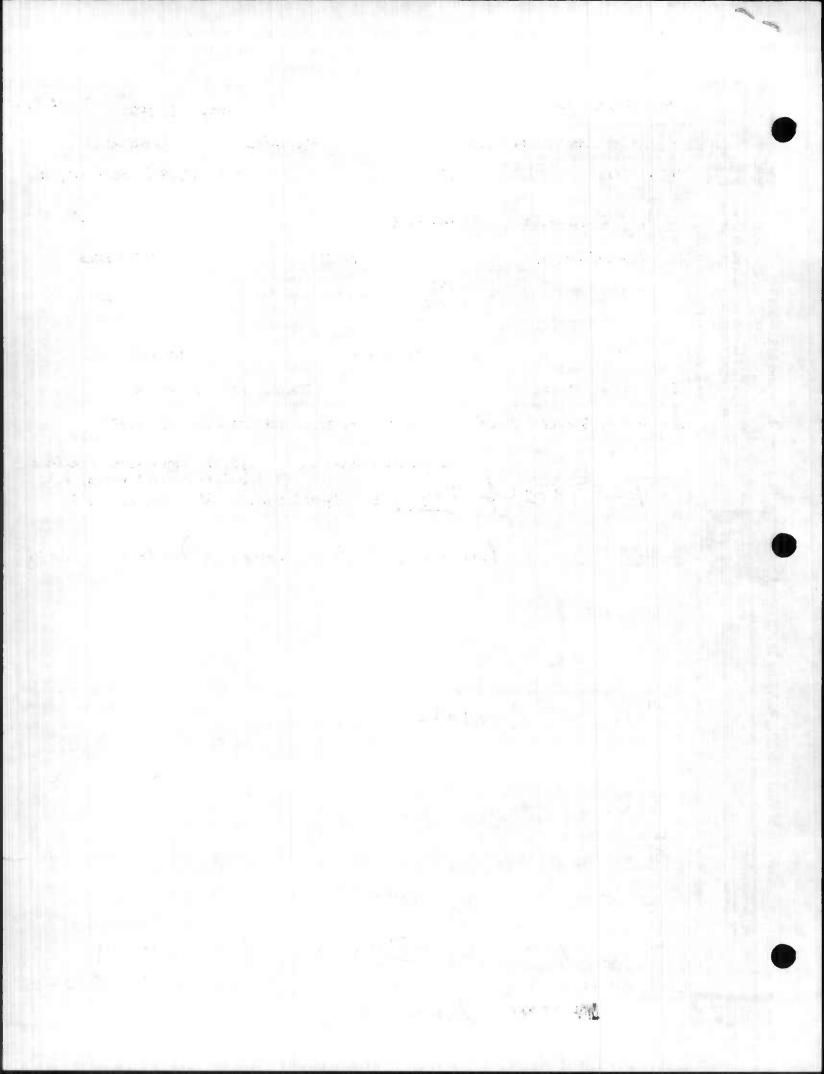
State • Registrar

30. Name and address of person who completed causa of daeth (Itam 23a) (Type, Print)

(100) Casper E. Ttt Mit.

31. Date filad (Month, Day, Year)

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Tima of Death Day Month Gladvs. Elizabeth Staley March 3, 4:45P.M. 1999 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Health Care Center Frederick Frederick If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours 10 M ARE 216-05-4357 84 May 14, 1914 Maryland Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick XM Yes 2 □ No 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code 1421 Taney Avenue 21702 U. S. A. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, Whita, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yas 2 ☐ No Specify: Specify: white 3 ☐ Widowed 4 🖰 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ruth Elizabeth Heffner unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31 Challenger Court, Walkersville, Maryland Larry Staley - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Resthaven Memorial Garden Mar 6,1999 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Stauffer Funeral Homes, P. A. 21. Signature of Funeral Service License 1621 Opossumtown Pike, Frederick, Maryland 21702 RRA 23a. Part1. Epte the disease, or complications that caused the de shock, or heart lailure. List only one ceuse on each line. ath. Do not enter the mode of dying, such as cardiac or raspiretory errest, Approximate Intervel Between Onset and Deeth Immediate Cause (Finel disease or condition resulting in death) week evelovovas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) thous sclevesis 1129115

Physician /Medical Examiner

physician and s the burial-transit

for use as

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cartificata

To the Hospital or Attending Physicien: Within 24 hours effer death.

To the Funeral Director: Affer this cartifica completely filled in by the funeral director; g

The law requires that the death certificate be executed

Division of VItal Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a State

Director

Funeral

à

Completed

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Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglena. Important: if itam 27 is marked other than "naturel", or hema 23a or 28a-f show any injury or other traumatic avent, the Medical Examiner must be incorrect at the Debas.

Saltimore, Maryland 21215-0020

that initieted events resulting in death) Last	Due to (or es a consequence of):		
Part II. Other significant conditions on Prior St		sulting in the underlying	cause given in Pert I.	23b. Did tobacco use co	ntribute to the cause of death?
Hyperte				24a. Wes an eutopsy performed?	24b. Ware autopsy lindings available prior to completion of cause of death?
25. Was case referred to medical			00.00 (0	1 Yes 25 No	1 Yas 2 No
everniner?	Hospital: 1 Inpatient 2	ER/Outpatient 3 1	Othor	eeth (Check only one) Home 5 ☐ Residence 6 ☐ Oth	ner (Specify)
27. Manner of Death 12 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injury at Work?	28d. Describe how Injury occur	
3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, lactory)	ory, office	28f. Location (Street and Numb City or Town, State)	ber or Rural Route Number,
29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	rsician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	d et the time, date and place on, in my opinion, deeth occ	ee, and due to the cause(s) end ma curred et the time, date end plece,	anner es stated. and due to the cause(s)

29c. License number

187 THOMAS JUHNSON DRIVE FREDERICK, MD 21707

29d. Data signed (Month, Day, Year)

State Registrar

29b. Signature and title of certifier

LIAM H

31. Date filed (Month, Day

DHMH 16 Rev 6/95

ess of person who completed cause of death (Item 23a) (Type, Print)

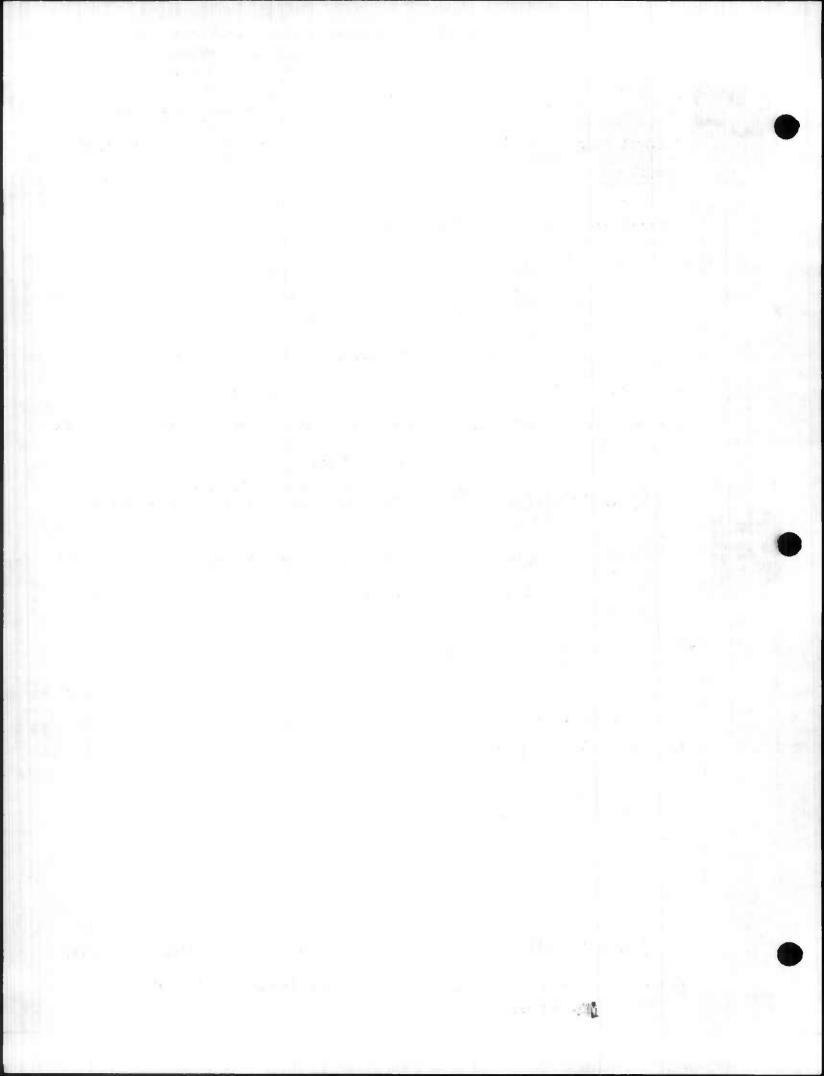
1999

32. Registrar's Signature

JUHNSON

State of Maryland / Department of Health and Mental Hygiene 9

Physician //Medical Examiner Physician //Medical Examiner Sequentially list conditions, if any, leading to immediate cause (Interval Between Onset end Deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ca	_						Certifica	te of	Death		Reg. No.	V. 1	The Suit Stee		
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Shady Grove Advertist Hospital Private Director Direct						tano	chfiel			1			0700 AM		
Social Security Number Control 100		Exami	ner						4b. City, Town, o	r Location of Dea	th 4c. County	of Deeth			
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Three Part		Physician		shock, or heert failure. List only	/ ane ceuse on each line).		•				i	intervel Between		
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25. Wes case referred to medical exeminer? 1	<u> </u>	The late he	MO.							1 🗆	Yes 2 No	1 🗆	Yes 2□ No		
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		Sta	te					- 200	4	F	-011				



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Death 3. Time of Death Month Physician Norman Edward Sullivan February 28, 1999 6:00p.m. /Medical 4e. Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kent & Queen Anne's Hospital Chestertown Kent Hunder 24 Hrs. 8. Date of Birth (Month, Day, Year) (Country) March 7, 1921New Castle, DE 6. Sex }OXM 2□ F If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Director 221-05-7850 77 Yrs. Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Wed cal Examinar must be notified at 1X Yes 2 □ No Directo Maryland | Kent Rock Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Chesapeake Villa 21661 USA Funeral 12. Was Decedent Ever in U,S. Ammed Forces?

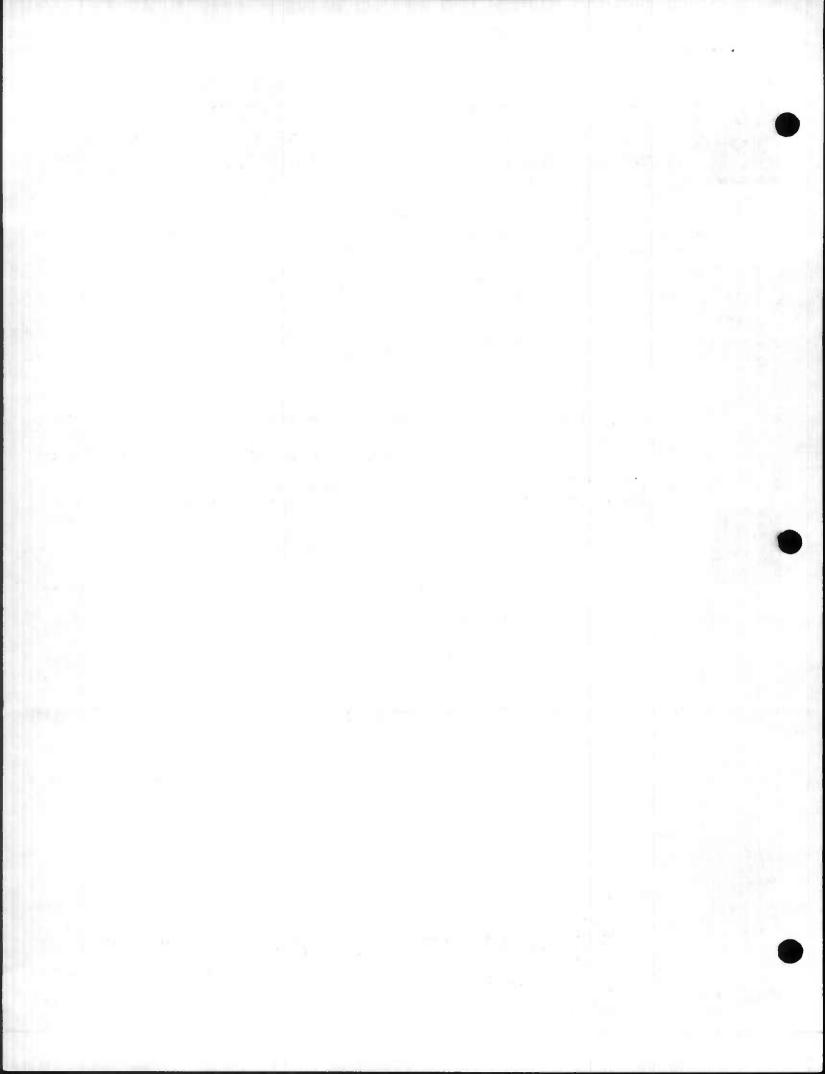
**YOAYes 2 □ No If Yes, Give Year or Dates: 1942–1945 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 200No Spacify: ₩idowed 4 Divorced Specify: White þ Completed 16a. Decadent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry 2 should be filed within 7, end Mental Hygiene. s marked other than "n Elementery/Secondary (0-12) College (1-4or 5+) Communications/Telephone District Supervisor permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other only injury or other traumatic averted. 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Surnama) Be Percy Berriadge Sullivan Sarah Melvin Davis 19a. Informant's Name/Relationship (Typa, Print) 19b. Mailing Address (Straat and Numbar or Rural Routa Number, City or Town, Steta, Zip Code) Sarah Lee Hinefelt/Daughter 1757 Brightwell Court, Waldorf, Maryland 21620 20b. Place of Disposition (Nema of camatary, cramatory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Spacify) 3/5/99 Wilmington, DE Gracelawn Memorial 21. Signature of Funerel Service Licens 22. Name end Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final Cardio pulmonary Appent disease or condition resulting in deeth) Examiner Physician/Medical Examiner YFOTEUSEUN

Due to (or as a consequence of): physician end s the buriel-transit certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest P.O. Box 68760. Delighection
Dig to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Hypertension, Decreased level of Consciousness, signed I Records, Be Completed by 24a. Was en autopsy performed? 24b. Were autopsy findings eveilable prior to completion of ceuse of deeth? COPD, H/O Gout, H/O tobacco + Alcolent ABure, Semile Sementin 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was cese referred to medical examiner?

1 Yes 2 1400 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 27. Menner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Investigation n 24 hours efter death.

• Funerel Director: A pletely filled in by the fu r death. 1 ☐ Yes 2 ☐ No None 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 4 Homleide 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier within 24 hor To the Fune completely fi Medical (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8 023889 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Jr, M. d. 948 Wishington Ave, CHestertown, Med 21620 32. Registrar's Signeture Day, Year) State Registrar

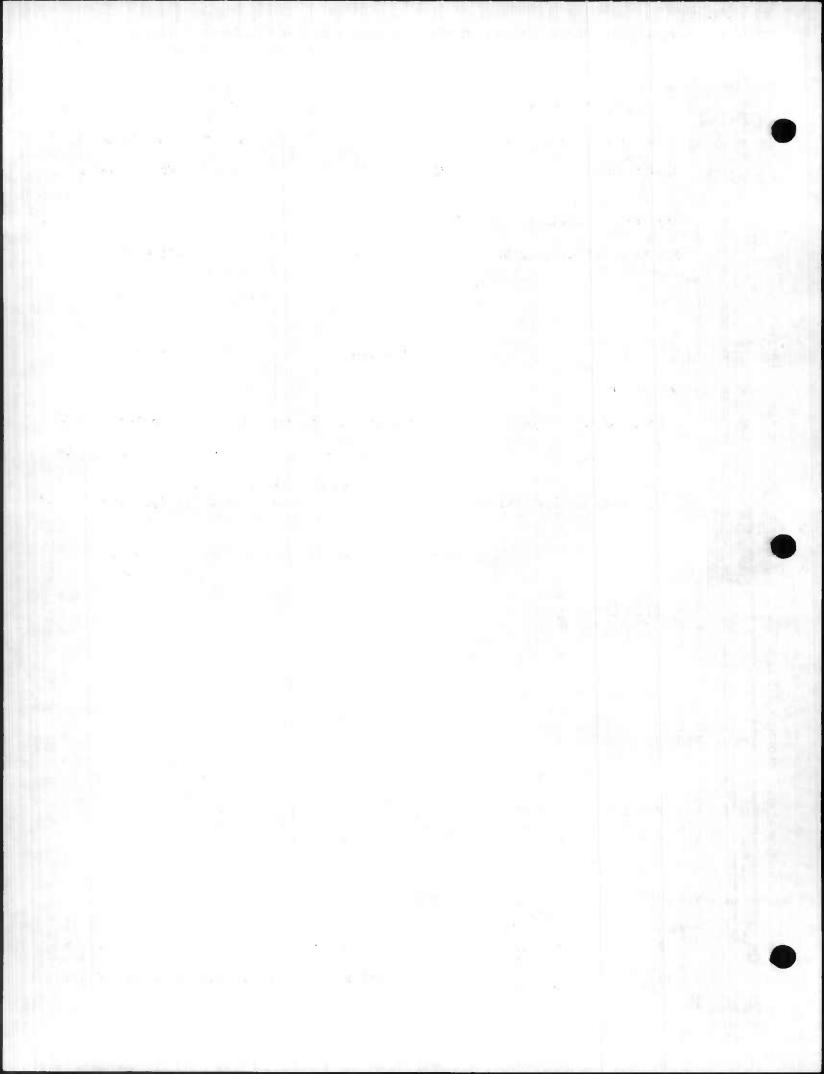
_			State of Marylan	d / Department of I Certificate of			ene 99	08584
	Physic /Medi		1. Decedent's Neme (First, Middle, Last) Sarah Bayly Schlaick			2. Dete of Deeth Month March 2,	Dey Ye	3. Time of Death 7:05PM
	Exami		4a. Fecility Neme (If not institution, give street and number) Chesapeake Woods Center		4b. City, Town, or L. Cambri	ocation of Death	4c. County of E	-0000
	Funeral Director	Г	5. Social Security Number 213-22-7667 6. Sax 7. Aga (In yrs. I	ast birthday) If Under 1 Yaar Months Deys	If Under 24 Hrs.	8. Date of Birth (Month, Dey, July 1,		Birthpleca (State or Foreign Country) Maryland
1	anyland show id at	١		, Town or Location				10d. Inside City Limits
5	with the Marylan s or 28a-f show be notified at	Directo	Maryland Dorchester 10e. Street end Number	Cambridge 104. Zip Code		10	g. Citizen of Whet	t Country?
020 NG	urs after death w it', or thems 23a xaminer must b	by Funeral	11.4 Somerset Avenue 11. Maritel Stetus 1 □ Naver Married 2 □ Married 30 Widowed 4 □ Divorced 12. Was Decedent Evar in U; Armed Forces; 1 □ Yes 2 □ No If Yes, Giva Yaar or Detes:	216 S. 13. Was Decedent of I If Yes, specify Cub		pecify Yas or No- Rican, etc.)		American Indian, White, etc. White
Maryland 21215-0020	d within 72 hos glens. Ir than "nature she Medical E	Completed	15. Decedant's Education (Specify only highest grade completed) Elemantery/Secondery (0-12) Collega (1-4or 5+)	16a, Decedent's Usuel Occu (Give kind of work done life. DO NOT use retire	during most of work	ring	6b. Kind of Busine	ess/Industry Home
yland	wild be filed Mental Hygi infrad other afte event, I	To Be C	17. Fether's Neme (First, Middle, Last) A. Shepherd Bayly	TO MONITOR	18. Mother's Nem	a (First, Middle, Mi Harringto		
	and 2 sho ealth and n 27 is me		19e. Informent's Neme/Relationship <i>(Type, Print)</i> Robin M. Kirwan II Son	19b. Meiling Addrass (Street 4651 Maple				
altimore,	Pages 1 ment of H ant; if her ury or oth		VIVBuriet 2 Cremetion 3 Removel from State	ece of Disposition (Name of ematery, cremetory or other pla d Trinity Churc			oc. Location - City nurch Cre	or Town, State eek, Maryland
Ball	Depart Depart Import any in		21. Signature of Juneral Sarvice bicensae	22. Name end Addre Thomas Fur 700 Locus	neral Home		Maryla	and 21613
	Physician /Medical		23a. Pert VEnter the disaase, or complications that caused the deeth shock, or heart failure. List only one ceusa on each line. Immediate Cause (Final	. Do not antar the mode of dylic delay.	ng, such es cardiec	or raspiretory erres	st,	Approximete Intervel Batween Onset end Deeth
	Examiner	ner	resulting in deeth)	as e consequence of):				Years
60,	ficata be executed physicien and is the buriel-transit	Examiner	if any, leeding to immadiate cause. Entar Indertying Causa (Diseasa or injury	as a consequence of):				year.
Box 68760,	death certificata I e attanding physis of for use es the b	n/Medical	that initiated execute	es a consequenca of):				yean,
P.O. B	0 0 2	Physician/M	Pert II. Other significent conditions contributing to death but not resu	Iting in the underlying cause give	ven in Pert I.	23b. Did tob		uta to the causa of death? Probably 4 Unknown
of Vital Records,	een s	Completed by) }		24e. Wes en performe		Bb. Wara autopsy findings avallable prior to complation of causa of daath?
tal R	ician: The law certificate hes b rector, page 2 s	Be Com	25. Wes case refarrad to medical		26 Place of Deat	1 ☐ Yes	2 NO	1 ☐ Yes 2 ☐ ANO
	\$ 00	ို	27. Manner of Death	ER/Outpetient 3 DOA Ott 28b. Time of Injury M M Ott 28c. Injur Wor 1	ner: 4 Nursing Ho	ome 5 Residen 28d. Dascribe how	ce 6 Other (S	Specify)
DIX	2 4 4 6	al Certification:	3 Suicide 4 Homicide 28e. Place of Injury - At hor building, atc. (Specify,			City or Town,	Stete)	r Rural Route Number,
	To the Hospital within 24 hours a To the Funeral C complately filled	Medical	(Check only one) 2 Medical Examinar: On the basis of axaminetic end mannar steted. 29b. Signature and tipe of contribor	on end/or invastigation, in my o	ppinion, daeth occurr	ad at tha tima, dat	e end plece, and d	due to tha cause(s)
	6 4 € 4)My					
			30. Nama and eddrass of persen who complated cause of deeth (Item	23e) (Type, Print)	0987 ~ m	Tect	Cumbo	idgumo
	Sta Registr		31. Date filed (Month, Day, Yeer) 4 1999 32. Registrar's Signet	J. Soa	ress			21613



ASP

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 0 0 8 5 8 5

		Reg. No.											
Dhysisian	1. Decedent's Name (First, Middle,	Last)					2. Date of D	3. Time of Dea					
Physician /Medical Examiner	Orlando J. I	Corobo						FEBRU		7 1999	2015 P		
	4e Facility Name (If not institution, g					41	o. City, Town, o	r Location of Dea	ith 4c. Cou	nty of Deeth			
	531 RANDOLPH	RD APT#3	37a				SILVER	SPRING	MON	GOMER	Y		
uneral irector	325-52-1013	Sex 7. Ag	ge (In yrs. la: 74	st birthdey) Yrs.	If Under 1 Months	1 Year Deys	Hours Min	n. (Month, C	irth 1, 1924	9. Birthi Copi C1	place (State or Fo nto) 1Da		
>	Usuel Residence of Decedent 10a. State 10b. County		100 City	Town or Loc	nation						Ind Incide City I		
r 28a-f show inouffed at frector											1 ☐ Yes 2√		
etc off	Maryland Montgo	omery	Silve	er Spr	_								
0 M	10e. Street end Number 531 Randolph Roa	ad, #337A			10f. Zip 0				10g. Citizen of Whet Country? United States				
Art, or items Examiner in by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 2 If Yes, Give Year or Detes:	Ever in U,S. No		Vas Decede f Yes, specif		spanic Origin? (n, Mexican, Pue Specify: C1		Specify Yes or No- to Rican, etc.) 14. Race - American Black, White, etc Specify: White				
or than "natural", it, the Medical Exit Completed by	15. Decedent's (Specify only highest)			18a. Decede	lent's Usual	Occupa	tion	ndrina	16b. Kind of	Business/In	dustry		
npie	Elementary/Secondary (0-12)	College (1-4or :	5+)	life. D	OO NOT use	e retired)	uring most of w	OIKIII					
other th	8			Hou	ısekee	ping	3		Hot	el			
e e	17. Fether's Name (First, Middle, La	st)					18. Mother's N	ame (First, Middl	e, Maiden Sum	ame)			
To E	Duilio Torobo						Arace	li Paez					
E E	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing	g Address ((Street a	nd Number or I	Rural Route Num	ber, City or To	vn, State, Zij	Code)		
ther tra	Orlando Torobe	(son)		5525	West	22nc	d Court	, Hialea	h, Flor	ida	33016		
important: if itsm any Injury or othe ance.	20a. Method of Disposition 1 Buriai 2 Cremation 3 4 Donation 5 Other (Special Control of Control		cen	nce of Dispos metery, crem e of H	natory or oth	her place		Date 3-3-99		n-City or To	ng, MD		
ysician ledical aminer	23a. Pert1. Enter tha disease, or co	omplications that caused	d the death.				Avenue,			Haly	Approximete		
ledical aminer	23a. Pert1. Enter the disease, or conshock, or heart feilure. List on Immediate Ceuse (Finel disease or condition resulting in death) Sequentially list conditions,	a. Itypo	Due to (or a		er the mode Att	of dying	, such es cardi		arrest,	1	Approximete Interval Betwee Onset and Deal		
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Is been signed by the attending physician end 2 should be detached for use es the burial-transit au particular and a physician/Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest	a. Hyper	Due to (or a	Do not ente	uenca of):	e of dying	such es cardi	23b. Die 24a. We per	di Ovus di 3ec	contributa t	Approximate Interval Betwee Onset and Deal		
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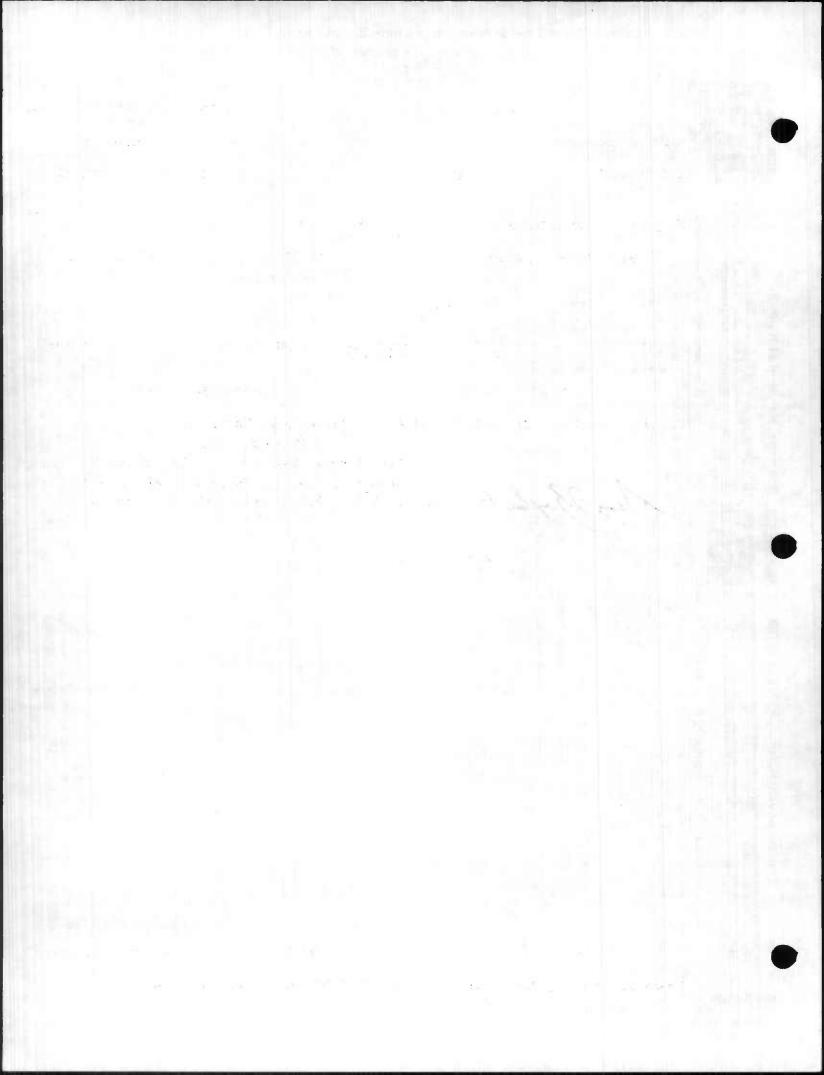


State of Maryland / Department of Health and Mental Hygiene 9

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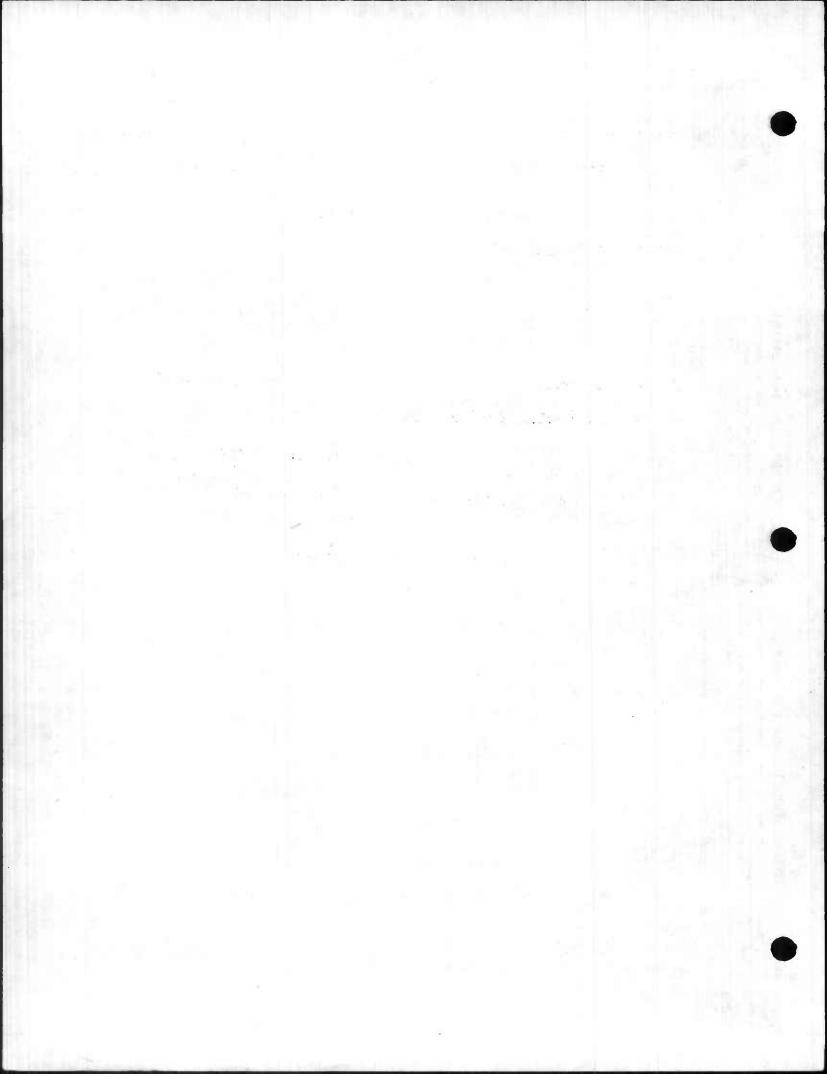
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Registrar



State of Maryland / Department of Health and Mental Hygiene Q Q 0 9597

	Certifi	cate of Death	Reg.		0001
	Decedent's Nama (First, Middle, Last)		2. Dete of Death Month	Dey Yeer	3. Time of Deeth
ysician Iedical	LUVENIA S. TURPIN		March	1, 1999	1:00 PM
aminer	4a Facility Nema (If not institution, give street and number) Mariner Health of Laurel	Lau	rel	4c. County of Death Prince	Georges
neral ector		Under 1 Year If Under 24 Hrs onths Deys Hours Min		1901 Ma	placa (Stete or Foreign ntry) lyland
	10a. Stata 10b. County 10c. City, Town or Location	on .		1	IOd. Inside City Limits
Examiner must be notified at	MD Prince Georges Be	ltsville			1 X Yes 2 № No
Director	10e. Street and Number 11810 Ellington Drive	0f. Zip Code 2 0 7 0 5	10g.	Citizen of What Cour	niry?
era			Specify Ves or No.	14. Race - Amaric	can Indian
leted by Funeral	1 Never Merried 2 Merried 1 Yes 2 No	Decedent of Hispanic Origin? (5, specify Cuban, Mexican, Puer res 2000) Specify:	to Rican, etc.)	Bleck, White,	
et e	(Specify only highest grade completed) (Give kind	s Usual Occupation of work done during most of wo	nrking 16t	b. Kind of Business/In-	dustry
Completed	Elementary/Secondary (0-12) College (1-4or 5+) 6 th Dome	OT use retired)		Home	
	17. Father's Name (First, Middle, Last)		me (First, Middle, Mei		
To Be	George W. Smith		V. John		
To Be Comp	19a. Informent's Neme/Relationship (Type, Print) Great 19b. Mailing Action Torreah L. Benton (Niece) 839 C	opley Ave.,	Waldorf,	ity or Town, State, Zip MD 2060	Code)
	20a. Method of Disposition 10 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition cemetery, cremetor, Md. Nat'l	y or other place)		Laurel,	
Suc Suc Suc Suc Suc Suc Suc Suc Suc Suc		me end Address of Fecility OWDEN FUNERA CKVILLE, MD	L HOME, 20850	P.A.	Y Y
Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhileted events resulting in death) Last Lossississississississississississississi	20 of): D/52/20			Z OATS TEAMS
by Physician/M	Part II. Other algnificant conditions contributing to death but not resulting in the underty			cco use contribute to	o the cause of death?
Completed by	PSONIASIS	367	24a. Wes an a performed	d? av	ere autopsy lindings vailable prior to impletion of causa deeth?
Comp			1 ☐ Yes	2≅No 1/	□Yes 2∰No
Be	25. Was case referred to medical	26. Place of De	eth (Check only one)		
To	examiner? 1 Yas 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3	Other	Home 5 ☐ Residence	e 6 Other (Specif	fy)
	27. Manner of Death 1. Netural 5 Pending (Month, Day Year) 2 Accident investigation	28c. Injury at Work? 1 Yes 2 No	28d. Describe how	injury occurred	
ed in by the funera Certification:	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 28e. Place of Injury - At home, Ierm, street, for building, etc. (Specify)	ectory, office	281. Location (Stree City or Town, S	et end Number or Rure Stete)	el Route Number,
icai	29a. Certifier (Check only one) **PCertifying Physician: To the best of my knowledge, death occ 2 Medical Examiner: On the basis of examination and/or investigand manner stated.				
Med	29b. Signature and title of peridier	29c. License number		Date signed (Month,	Dey, Year)
	Con College	DSZASS	Mr	ency 1	11999
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature		-1-1400	50/01	
gistrar	MAR 04 1999 Serena G.	Sporks			



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Data of Death 1. Decedant's Nama (First, Middla, Last) **Physician** Wilton Roy Todd 1999 Feb 27 6:40 AM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, giva street and number) **Examiner** Genesis ElderCare -The Pines Easton If Undar 24 Hrs. Talbot If Under 1 Year Birthpleca (State or Foreign Country) 5. Social Security Number 7. Aga (fn yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** 1√ M 2□ F Months Days Hours Min. 94 Yrs. Director 214-34-5265 march 20,1904 | Maryland Usual Rasidence of Decedant with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits If is marked other than "natural", or frams 23a or 28a-f show traumatic svent, the Modical Examiner must be notified at 1 ☑ Yas 2 ☐ No MD TALBOT EASTON Director 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 610 DUTCHMAN'S LANE 21601 USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puerto Rican, atc.) 14. Race - Amaricen Indian 11. Maritel Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or then any injury or other traumatic svent, the Medical Examinat DRGs. 1 ☐ Yes 2 ☑ No If Yas, Giva Yaar or Datas: 1 Navar Married 20 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: WHITE pA 3 Widowed 4 Divorced Completed 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) SCHOOL TEACHER EDUCATION 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Sumema) ALBANUS B. TODD MARY C. JONES 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, Steta, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) ELIZABETH R. TODD/ WIFE 3807 RUMSEY DRIVE, TRAPPE, MD 21673 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data XXX Burial 2 Cramation 3 Ramoval from Stata WOODLAWN MEMORIAL PARK 3-6-99 EASTON, MD 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset end Death Physician Immediata Causa (Final disaasa or condition rasulting in daath) /Medical Examiner to (or es e consequence of): Examiner alie caremoma physician and s the bunal-transit certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury Due to (or es a consequance of) Physician/Medical Dua to (or as a consequence of): as the rasulting in daath) Last the attending 980 for Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I 23b. Did tobacco use contribute to the cause of death? detached Atheroscierosis, generalized 1 Yee 2 No 3 Probably 4 Unknown signed by g 8 24b. Were autopsy findings evailable prior to completion of cause ot deeth? Completed 24a. Was an autopsy Cerebrovascular manffrience performed? certificata has 1 Yas 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Placa of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No 2 27. Manner of Deeth 28e. Data of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28c. Injury at Work? epital or Attending Pinous after death.

neral Director: After tillied in by the funera 1 Netural 5 Panding invastigation 1 Yas 2 No 2 Accidant 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 6 Could not ba datarmined 3 Sulcida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida Hospital 24 hours a 12 Certifying Phyeiclan: To tha best of my knowladge, death occurred at tha tima, data and place, and dua to tha causa(s) and manner es statad.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and manner statad. edicai 29e. Cartifiar To the Hosp within 24 hor To the Fune completely fi 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifier 29c. License number

LASTON, MD

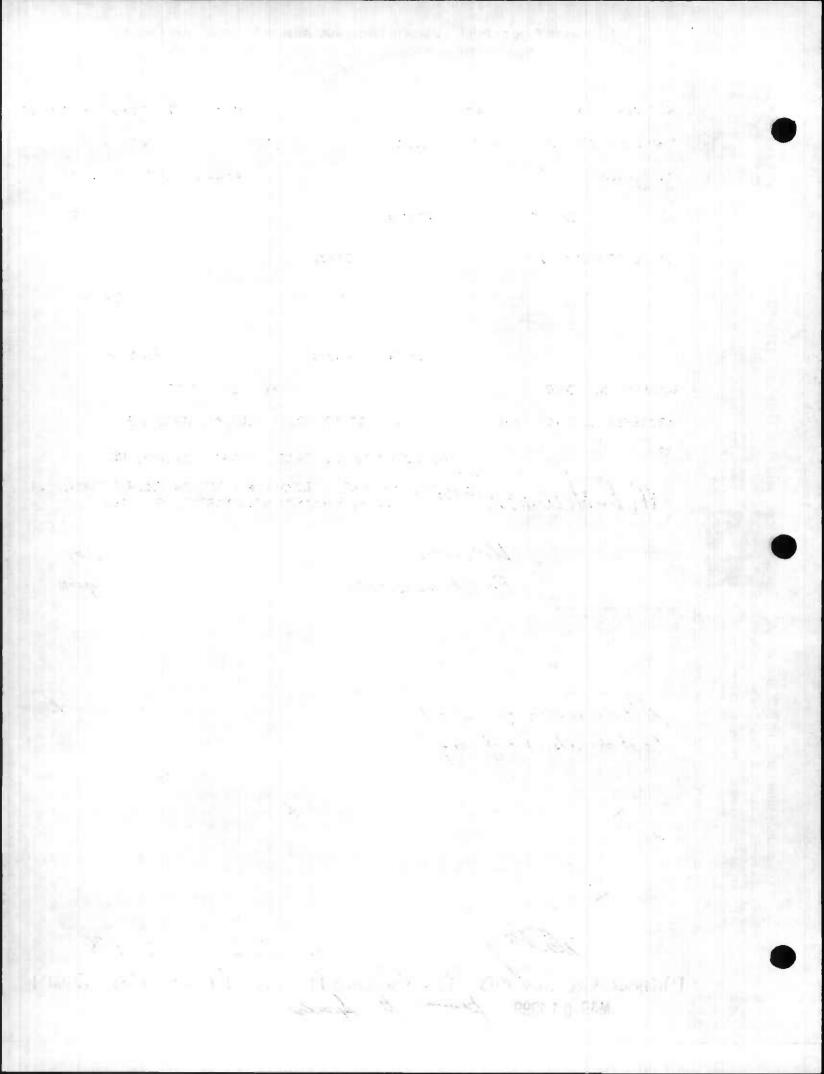
State Registrar 30. Nama and address of person who complates causa of death (Jtam 23e) (Type, Print)

CROWLEY

MD

32. Ragistar's Signature

508 IDEWILD 1-



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 118589 Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month : 10 AM MARCH Mildred Nora Turner 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Fallston General Hospital Fallston Harford If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number Birtholaca (State or Foreign Country) 7. Age (In yrs. lest birthday) 8. Data of Birth (Month, Day, Year) 1□M 25 F Yrs. 181-34-1548 Dec. 27, 1910 Pennsylvania Usual Rasidanca of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas No MD Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rock Spring Village 1 Colgate Drive Apt. 617 21050 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, atc. 11 Marital Status 1 Nevar Marriad 2 Married 1 ☐ Yas 2 ☑ No If Yas, Giva 1 ☐ Yas 2 ☐ No Specify: Specify: 3₺ Widowed 4 Divorced Yaar or Datas: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elemantary/Secondery (0-12) College (1-4or 5+) 12 Homemaker In home 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Jesse Bigler Catherine Weaver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. fnformant's Neme/Reletionship (Type, Print) Mrs. Mary K. McDonell (Daughter) 427 Woodcrest Drive, Aberdeen, Maryland 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Harford Memorial Gardens | 3/5/99 Aberdeen, Maryland 21. Signatura of Foharal Sarvice Licensee 22. Nama and Addrass of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that carsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death Immediata Causa (Final CONGESTIVE HEART 48 HOURS disaasa or condition rasulting in death) SEVERAL STENUSIS YEARS Sequentially list conditions, if any, laading to immadiata cause. Enter Undarlying Cause (Disease or injury that inhitated evants rasulting In death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Part ff. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autoosy JOINT 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa ratarred to medical examinar? 26. Placa of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of

Physician /Medical Examiner

Physician

/Medical

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Funeral

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Hygiene.

permit. Pages 1 and 2 should be Department of Health and Mental I Important: If them 27 is marked of

Baltimore, Maryland 21215-0020

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Mildred

Director

Funeral

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Be

Examiner physician and s the burial-transit Physician/Medical 3 signed b þ Completed certificate Be Medical Certification: To

be executed P.O. Box 68760, Records, Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Registrar

1 Neturel

2 Accidant

3 Suicide

29e. Cartifier

4 Homicide

29b. Signatura and titla of certifian

5 Pending

invastigation

6 Could not be determined

48HYANKIR

28a. Plece of tnjury - At homa, tarm, street, tactory, office building, atc. (Specify)

29c. License number

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year)

28t. Location (Street and Number or Rural Route Number, City or Town, State)

MARCH

BELAIR MD 21014

30. Nama and addrass of person who complated causa of death (flem 23a) (Type, Print)

2 NORTH AVE

32. Registrar's Signatura south

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State of Maryland / Department of Health and Mental Hygiene 🔾 🔾

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by t		3 ☐ Suicide 6 ☐ Could not determine	28f. Location (Street and Number or Rurel Route Number City or Town, State)					Route Number,							
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Registrar	1	MAR -	9 1999 🕨	Screw	~	B. Se	Cella!								

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Lester 1999 5 March 3:20 pm 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Deys Hours 10XM 2□ F 16 Yrs. 215-18-2762 27,1922 Frederick Md Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Frederick Brunswick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1100 Peach Orchard Lane 21716 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgln? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Spacify: White Specify: 3 ☐ Widowed 4X Ovivorced 16a. Dacedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry Darr's Tavern Elamantary/Secondary (0-12) Collaga (1-4or 5+) Brunswick, MD Owner & Operator 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meidan Sumama) Harold Arlie Taulton Beulah Catherine Beachley 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) David L. Taulton, Son 568 El Caminito, Livermore, CA 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete ♦ Burial 2 Cremation 3 Ramovel from State Park Heights Cemetery 3/9 Brunswick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Libense Barbara A. Wi thellan 22. Name and Address of Facility John T. Williams Funeral Home Williams, Owner arbara Α. 100 Petersville Rd Brunswick MD 21716 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediata Causa (Final disease or condition rasulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to Immediate ceuse. Entar Undarlying Cause (Disease or Injury that initieted events resulting In death) Last Due to (or as a consequence of): Due to (or as a consequence of): Port II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1) Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed?

Physician /Medicai Examiner

Examiner

Physician/Medical

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Completed

Medical Certification: 29

25 Be

31. Date filed (A

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

7 is marked other than "natural", or itsms 23s or 28s-f show trsumstic event, the Modical Examiner must be notified at

pemit. Peges 1 end 2 should be filed within 72 hours eftar. Department of Health end Mental Hygiena. Important: if Item 27 is marked other than "natural", or ites eny injury or other traumatic event. Its Marcail

Maryland 21215-0020

Baltimore,

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death

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After this certificate To the Hospital or Attanding Physician: within 24 hours aftar death.

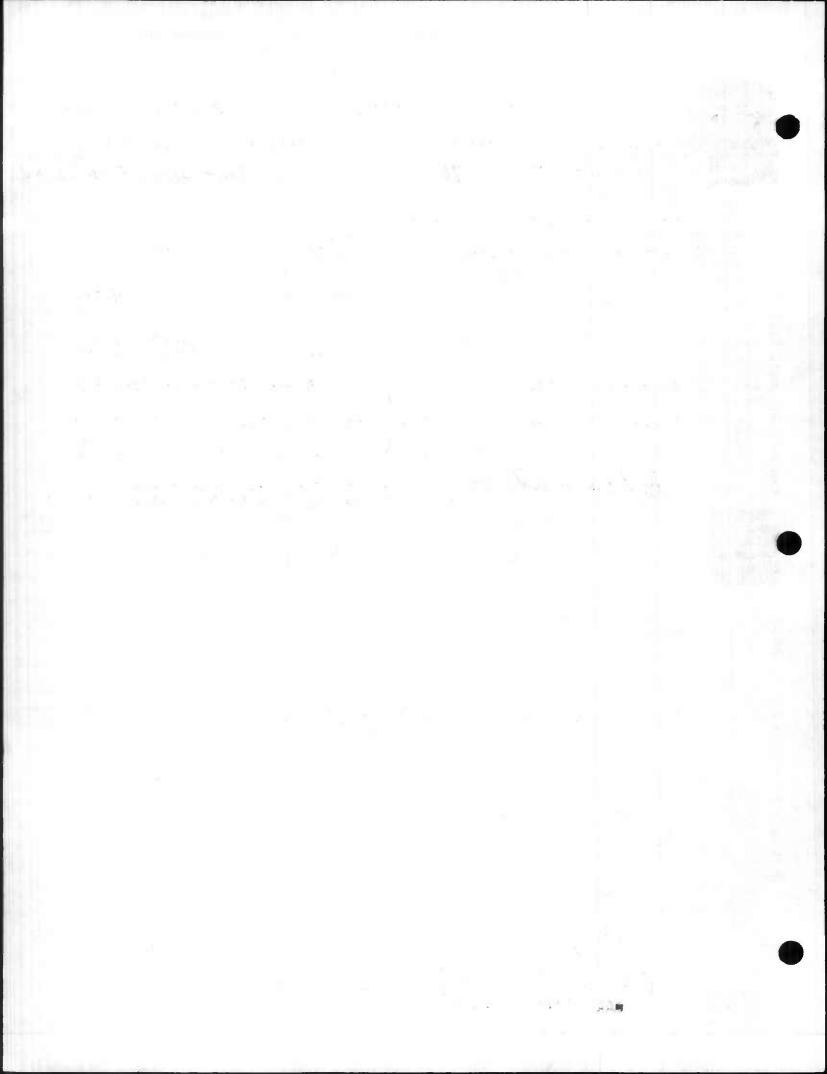
To the Funeral Director: Aftar this cartifica completaly filled in by the funaral director;

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27. Manner of Deat 1 Natural 2 Accident	5 Panding invastigation		28b. Time of Injury M	Injury at Work? 1 □ Yes 2 □ No	28d. Dascribe how injury occurre	ed					
3 ☐ Suicide 4 ☐ Homicide	6 Could not be datermined	28e. Place of Injury - At I building, etc. (Spec	home, farm, street, factory, of	fice	28f. Location (Street end Number City or Town, Stete)	r or Rurel Route Number,					
29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	yaician: To the best of my kn ninar: On the basis of examin and manner stated.	owledge, death occurred at the ation and/or investigation, in	ne tima, data and plac my opinion, daath occ	ce, and due to the cause(s) and man currad at tha tima, data and place, a	ner as stated. nd due to the cause(s)					
29b. Signature end	Affile of certifier		_	cense number	29d. Date signed	(Month, Dey, Yeer)					

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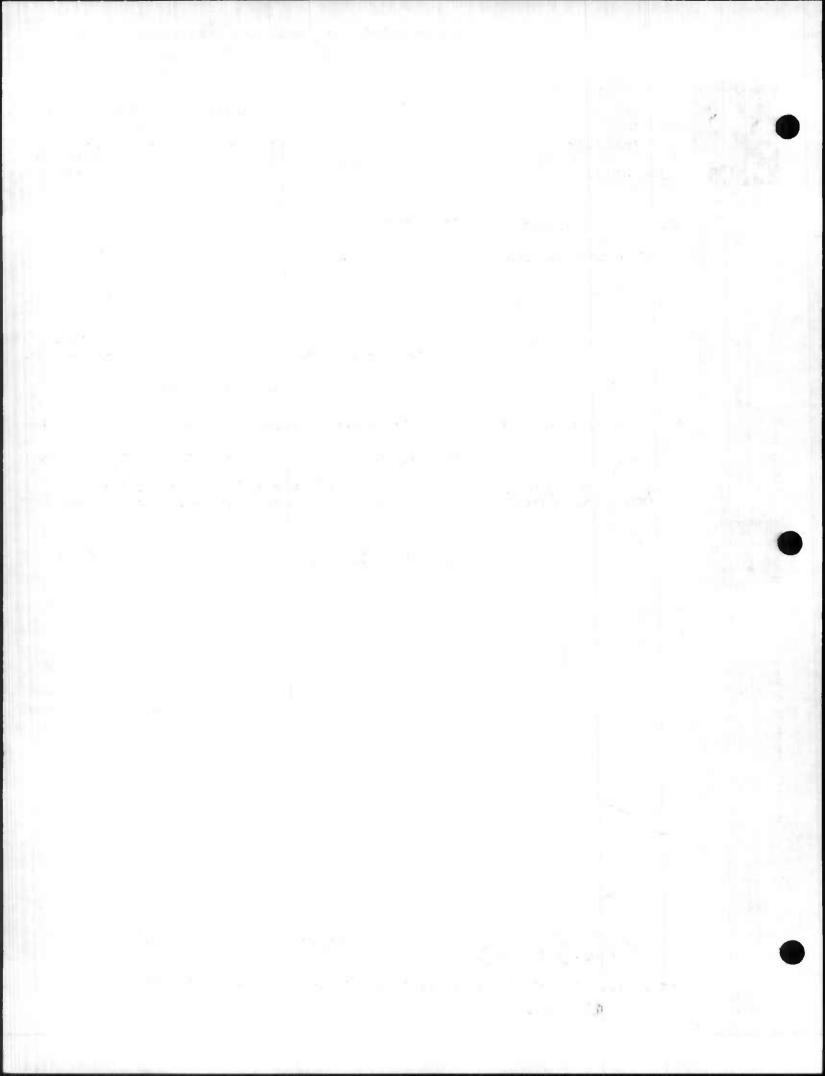
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State Registrar

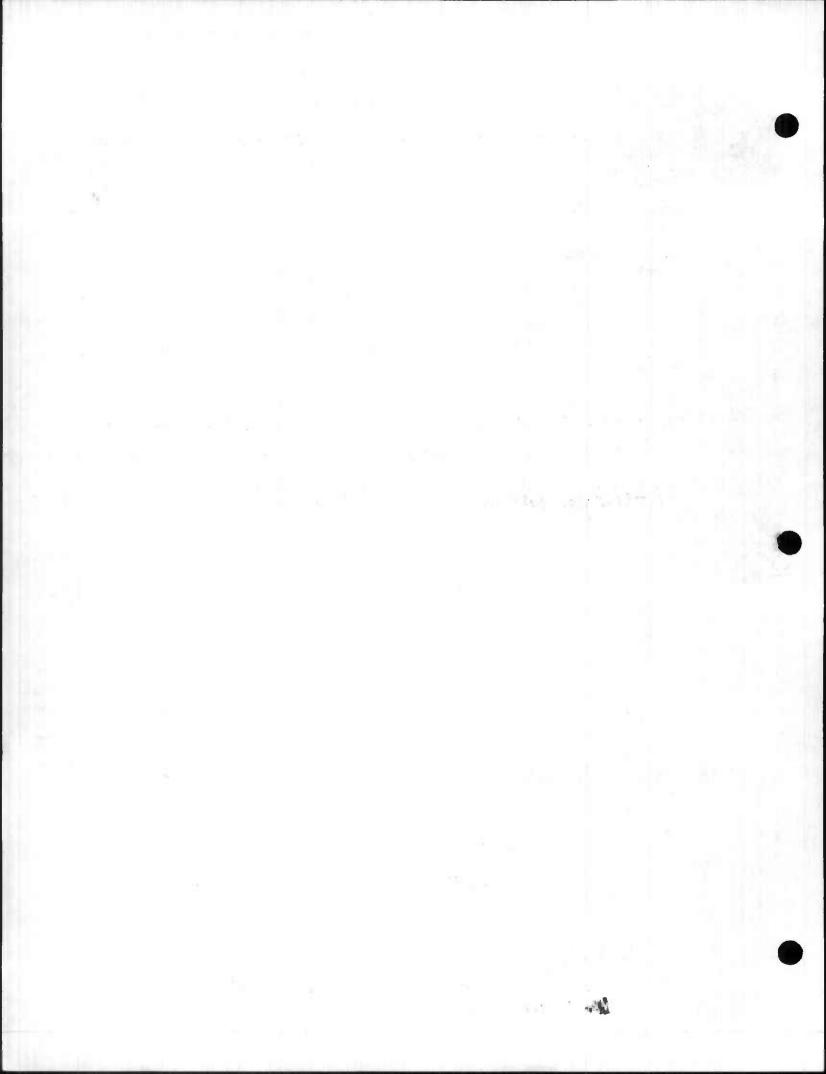


State of Maryland / Department of Health and Mental Hygiene

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Physic				t I.e.	Tester	rman		Month	Day	Yeer	
/Med Exami		4e. Fecility Name (If not institution			- 103001	man	4b. City, Town, or	March Location of Deet		of Death	6:20pm
Exami	1161	25625 Frederick					Clarks	hura			P17
Funeral		5. Sociei Security Number	6. Sex 7. /	Age (In yrs	. last birthday)	if Under 1 Yea	r If Under 24 Hr	8. Date of Bi	rth .	gome 1 9. Birthple	ace (State or Foreity)
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289	Director	Maryland Montg	omery	C1	arksbur	-			40- 014		
th with	al Dir	25625 Freder	ick Road			10f. Zip Code	871		10g. Citizen of V	U.S	•
de de	Funeral	11. Maritel Status	12. Was Deceder Armed Forces	nt Ever in t	J,S. 13. W	as Decedent of	Hispanic Origin? (Specify Yes or No	0- 14. Rac	e - America k, White, e	
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	Be	17. Father's Name (First, Middle, I	ast)				18. Mother's Na	me (First, Middle	, Maiden Sumem	e)	
	To	Unknow	n				Ett	ie Test	erman		
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Heeith am 27 is		Gladys L. Teste	rman - Wife	e	25625	Freder	ick Road	. Clarks	burg, Ma	rvlan	d 20871
		20a. Method of Disposition		20b.	Place of Disposi	ition (Neme of	lece)	Date	20c. Location -		
O = 0		1 Buriei 2 □ Cremation 4 □ Donaldon 5 □ Other (Sp			nocacy			3/8/99	Beallsv	ille,	Marylan
nit. re bertmen ortant: Injury		21. Signature of Funerei Servica I			22.	Name end Add	ress of Fecility				
Depe Impo		1 to - 7	21.11.)	01	in L. M	olesworth				
		222 Part Total the disease of	Villiam	cs do	126	401 Rid	ge Road,	Damasc	us, Mary	land	20872-0
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Physi /Med		1. Decedent's Neme (First, Middle, Last) Barbara Ann		TOLLIVER		2. Date of Dee Month March	01, 19	3. Time of Death 999 9:00 am
Exam		4e. Facility Neme (If not institution, give street and number 1000-F Heather Ridge Drives Social Security Number 6. Sex 7. A	,	If Under 1 Yaar I	City, Town, or Lo Freder f Under 24 Hrs.	ick		ederick
Directo	_	573-40-3195 1 M 2 M F Usual Residence of Decedant	65 Yrs.	Months Deys	Hours Min.	May 05	, 1933	9. Birthplace (Steta or Foreign Country) California
e Marylan	Director	Maryland Frederick	10c. City, Town or L Frederic					10d. Inside City Limits 1 1 Yes 2 No
with the		100. Street and Number 1000-F Heather Ridge Driv	ve Apt 213	10f. Zip Code	702	1	0g. Citizen of V	
be filed within 72 hours after death with the Maryland tall thygiene. Id other than "netural", or items 23s or 28s-f show event, the Medical Exam or mail be notified at	by Funeral	11. Maritel Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced 1 Yes 2 H Yas, Giva Yeer or Detes	t Ever in U,S. 13.	Was Decedent of Hisp If Yes, specify Cuben,		cify Yas or No- Rican, etc.)	14. Raci	e - Americen Indien, k, White, etc.
Mail yidiili Z.I.Z.I.Z.O.Z.O.Z.O.Z.O.Z.O.Z.O.Z.O.Z.O.	Completed	15. Decedent's Education (Specify only highest greda completed) Elementery/Secondary (0-12) College (1-4or	(5+) /ife.	dent's Usuel Occupation of work done during DO NOT use retired)	on ing most of working	ng	Home F	siness/Industry
should be filed and Mental Hygis marked other amatic event, the	To Be	17. Fether's Neme (First, Middle, Last) (unk)		18	3. Mother's Neme	(First, Middle, I	Meiden Surnem	(unk)
of Heal	F	19a. Informent's Name/Reletionship (Type, Print) Mr. Thomas C. Nikirk/ P.R. 20e. Method of Disposition 1 □ Buriel 2 ⊠Cremetion 3 □ Removal from State 4 □ Donetion 5 □ Othar (Spacify)	20b. Plece of Disponentery, cre	osition (Neme of matory or other plece)	t Street	, Frede	rick, M.	State, Zip Code) Varyland 21701 City or Town, State rick, Maryland
permit. Peges Department of Important: If if eny injury or	NING	23e. Pert1: Enter the disease, or complications that ceuse shock, or heart failure. List only one cause on each) M00706	2. Name end Addrass of Keeney & LO6 E Churc	Basford Ch Street	P.A. Fi	meral l	
Physiciar /Medica Examine	i i	Immediate Ceuse (Final disease or condition resulting in death)	SWD					Intervel Between Onset end Deeth
cuted nd ransit	Examiner	Sequentially list conditions	Due to (or es e conse Due to (or es e conse	,				10yrs.
eath certificate be assecuted attending physician and for use as the burial-transit	edical	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events rasulting in deeth) Last	Due to (or as a consec	quence of):				
thet tha d led by the detached	by Physician/M	Pert II. Other eignificant conditions contributing to death	but not resulting In the u	underlying ceuse given	In Pert I.	23b. Did to	1-0	tributa to the causa of death
e law has b	Completed	Chronie Pain / Hypo Huppondion	Neuropa	etly		24e. Wes e perform	ned?	24b. Were autopsy findings aveilable prior to completion of ceuse of deeth?
	BeC	25. Wes cess referred to medical exemined?		2	6. Plece of Deeth	(Check only on		1 ☐ Yes 2 ☐ No
Physic this co	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpet			4 Nursing Hon	ne 5 Reside	nce 6 Othe	
tending leath. tor: After the fune	ation	1 Naturel 5 Pending (Month, D	ey Year) Injury	Work?	s 2 No	od. Dasonibo ne	w injury occurr	
To the Hospital or Attending Physician: within 24 hours effer death. To the Funerel Director: After this certific, completaly filled in by the funeral director,	Certification:	3 ☐ Suicida 6 ☐ Could not be 4 ☐ Homicide determined 28e. Plece of Ir building, e	njury - At home, ferm, strotc. (Specify)	reet, factory, office	2	8f. Location (St City or Town		er or Rurel Route Number,
To the Hospital or At within 24 hours efter or To the Funerel Direct completaly filled in by	edicai	29a. Certifier (Check only one) Certifying Phyeician: To the basis and menner s	of examinetion end/or in	h occurred et the time, vestigation, in my opini	dete end plece, a on, deeth occurre	nd due to the co	euse(s) end me ate end plece, e	nner es steted. and due to the cause(s)
To the within	M	29b. Signeture end title of bertifier		29c. License no D4770		2		(Month, Dey, Year) 01, 1999
S	tate	30. Name and address of person who combleted cause of Dung-Thu Nguyen, M.D., 1 31. Date filed (Month, 1948) 4 1000 32. Regist			, Freder	ick, Ma	ryland	21702



State of Maryland / Department of Health and Mental Hygiene Q 8594 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MARCH 1721, 1995 Physician 9:34 P.M Allen LeRoy Turnbaugh /Medical 4c. County of Death. 4b. City, Town, or Location of Death 4a Facility Name (Itnot institution, give street and number)
Saint Joseph Medical Center Examirjer owson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
NOV. 15, 1921 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthdey) **Funeral** Months 10XM 2□ F Deys Hours 77 166-12-6498 Maryland Director Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours effer deeth with the Meryland Depertment of Health and Mertel Hygiene. Important: if itam 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other traumatic event, the Medical Experiment. 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 ☐ Yes 2 No Director Baltimore Parkton 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code U.S.A. 21120 17303 Prettyboy Dam Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 № Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 N Married Specify: White 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondary (0-12) Engineer Railroad 12 18. Mother's Name (First, Middle, Melden Sumeme) 17. Fether's Name (First, Middle, Last) Carrie May Dailey Clarence W. Turnbaugh 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 17303 Prettyboy Dam Road, Parkton, MD 21120 Ruth Turnbaugh/Wife 20b. Place of Disposition (Neme of 20c. Location - City or Town, State 20a. Method of Disposition March 13 Mt. Carmel United Methodist Cemetery 1 N Burial 2 □ Cremetion 3 □ Removel from State Parkton, MD 1999 4 Donation 5 Other (Specify) 21. Signature of Fue eral Service Lic 22. Name and Address of Fecility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA

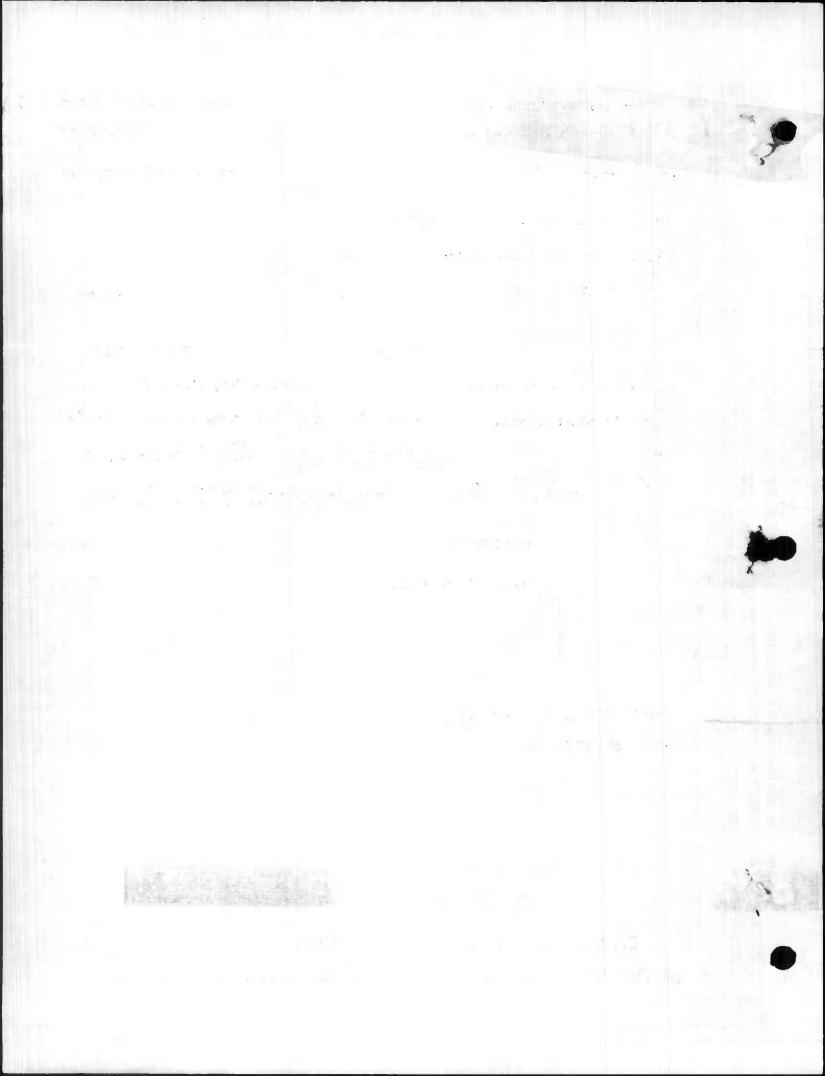
or the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, head failure. List only one cause on each line. conscern 17349 Approximate Interval Between Onset end Death iysician ASPIRATION 30MINUTE **Redical** Immediete Cause (Final Examiner Due to (or es e consequence of): CARDIAC ARRYTHMIA YEARS Examiner law requires that the death certificate be executed physician and the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) d for use es t Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CHRONIC ATRIAL FIBRILLATION þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Wes an autopsy ACUTE CHOLECYSTITIS certificate hes l 1 ☐ Yes 2 No 1 Yes 2 No To the Rospital or Attanding Physician: within 24 hours ariely death.

To the Funeral Director: After this certified completely filled in by the funeral director, Be 25. Wes cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ty⊡ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28e. Dete of injury (Month, Dey Yeer) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 T Homicide 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 28982 Momero ando 99 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ERLANDO ROMERO, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

MAR 1 7 1999

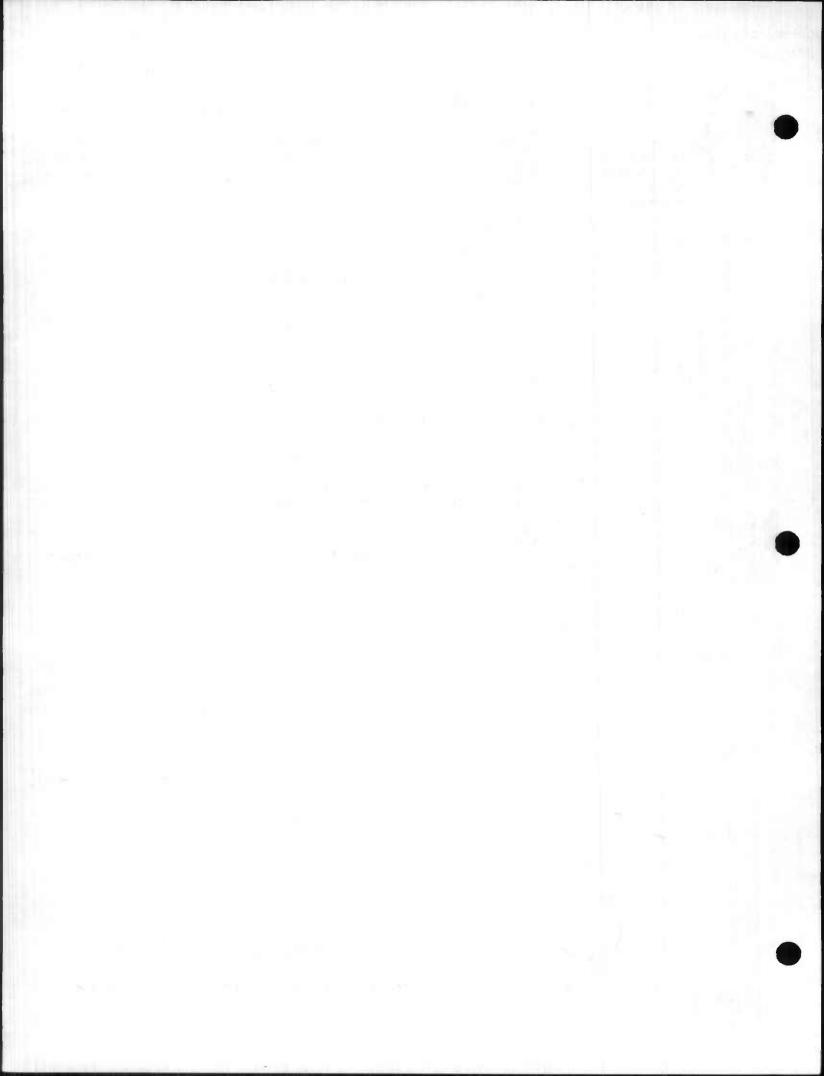
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State of Maryland / Department of Health and Mental Hygiene

S-0020 Wedge Examine France Examine	cal ner	1. Decedent's Name (First, Middle, I Pearl Louise 4e. Fecility Name (If not institution, g Genesis Elder Car 5. Social Security Number 6. 213-03-5405 Usuel Residence of Decedent 10a. Stata 10b. County MD Queen A	TYDINGS ive street end number e - Corsi		rsing H		4b. City, Town, or	2. Date of De Month Februa	Day	Year 1999	3. Time of Déeth 1:20 PM
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rs efter death with the Maryland r, or items 23e or 28e-f show saniner must be notified at	Director	10a. Stata 10b. County				Months Day		. (Month, D			ce (State or Foreign) nington, D(
120 rs efter death with the Maryl ", or ttems 23s or 28s-f sho xaminer must be notified a	Director	MD Queen A		10c. City	, Town or Loc	ation				10d	. Inside City Limits
)20 rs efter daath with th '', or term 23a or 28	Dire		nne's	St	evensv	ille					1 ☐ Yes 2 ☐ No
ns efter das	a	10e. Street and Number 9 Pettinot Cour	t			10f. Zip Code	21666		10g. Citizen of U.S	Whet Country	?
2 2 4	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 ☐ Yes ②☐ If Yes, Give Year or Detas	No		Ves Decedent of Yes, specify C	of Hispanic Origin? (5 uben, Mexican, Puer Io <i>Specify:</i>	Specify Yes or No to Rican, etc.)	5- 14. Ra Bla Specia	ce - American ack, White, etc).
within ena.	ompleted	15. Decedent's (Specify only highest g Elamantary/Secondary (0-12)	Education rade completed) College (1-40)	r 5+)	(Give k life. D		cupetion ne during most of wo ired)	rking		Business/Indus	stry
d Hilled	Ö	17. Fether's Name (First, Middle, Las	t)		ноте	maker	18. Mother's Na	ma (First, Middle	Seli Malden Sumai		
Maryland d 2 should be file th and Mental Hy 7 is merked othe traumatic event	To Be	George Harrison						ellman			
Aarylai 2 should b and Menti is marked		19a. Informent's Neme/Relationship	(Type, Print)		19b. Meiling	g Address (Stra	aat and Number or A	ural Route Numb	er, City or Town	, Stata, Zip Co	ode)
1 end 2 Health.		Delores Zimmermar	/ Daught	er	9 Pet	tinot (Court Ste	vensvil	le, MD 2	21666	
Baltimore, semit. Pages 1 er Department of Haa mportant: If item 3 nny injury or other ones.		20e. Method of Disposition 1 ☑ Burlel 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	□Removal from State	9 06	emetery, crem	atory or other p	olaca) Tial Park	Dete	20c. Location		
Baltimol permit. Pages Department of important: If it any injury or o		21. Signature of Funeral Service Lic		130	22.	Name and Add	dress of Facility Helfenbei				
	-	230 Farth From the America or do	nolloations that cause	Time leave			ock Road		er, MD		pproximate
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ords, P.O. Box 68760, requires that the death certificate be assocuted een signed by the attending physicien end hould be detached for use as the burial-transit	-	resulting in death) Last	d	Dua to (or	es e consequ	enca or).					
BOX aath cert attendin for use	clar									1	
that the danged by the a	Physician/N	Pert ii. Other eignificant conditions	contributing to death	but not resu	Iting in the un	derlying cause	givan in Pert i.		tobacco use co Yes 2□ No		ne cause of death? bly 4☐ Unknown
ds, Fuiras that	by							24a Was	en eutopsy	24b, Were	autopsy findings
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of Vital Physician: The this certificate ral director, pag	Be	25. Was case rafarred to medical exeminer?	He epitel.					ath (Chack only	one)		
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nding P ath. v: After	atlon	27. Manner of Death 1. ■ Natural 5 Panding 2 Accident investigati		ay Year)	28b. Time of Injury	28c. ir V M 1	ljury at Vork? □ Yes 2 □ No	28d. Describe	how Injury occu	rred	
Division of the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completaly filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not determine	289. Placa of II	njury - At hor etc. <i>(Specify</i>	ma, farm, stre	et, factory, offic	ce	28f. Location (City or To	Street and Num wn, State)	ber or Rural R	loute Number,
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o the o the omple	Me	29b. Signature and title of continer	Silve interior s		-		ense number		29d. Date sign		
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,		30. Name and address of erson who	completed causa of	_	23a) (Type, P	Print)) 3203 (Drive (0 /		211	/ 0
		31. Date filed (Month, Day, Yaar)	orse	2. / U Strar's Signat	8 D. D	onul	Drive (hoster 1	MU	161	1

DHMH 16 Ray 6/95



Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MELVIN UMBACH FEBRUARY 24, 1999 5:07 PM **JERRY** /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 1, 1936 Birthplece (State or Foreign Country)
 Ohio 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1√1 M 2□ F Yrs. 62 032-26-0184 Director **Usual Residence of Decedent** death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or frame 23s or 28s-f show the Medical Examinar must be notified at 1 Yes 2 No Directo Maryland | Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 19726 Greenside Terrace 20886 United States Funeral or Nerna 14. Race - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ∑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1959-1 Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced 1984 white 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Captain NOAA permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if item 27 is marked other any injury or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Melvin Harry Clarence Edna Stegman Umbach A . 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 20886 19a. Informant's Name/Relationship (Type, Print) 19726 Greenside Terrace, Montgomery Village, MD Jamie S. Umbach, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Feb. 25 20c. Location - City or Town, Stete 1 ☐ Buriat 2 ☐ Cremetion 3 ☐ Regardval from State 1999 tion 5 Other (Specify) Metropolitan Crematory Alexandria, Virginia stufe of Funeral Service/Licer 22. Name and Address of Fecility 21. Sig DeVol Funeral Home 20877 dec 10 E. Deer Park Dr., Gaithersburg, MD m, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Preumonia. Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 5 Due to (or as a consequence of): for use Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert It. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cardiomyopathy, Status-post Heart Be Completed by 24b. Were autopsy tindings available prior to completion of cause of death? Transplant 6 years ago, Renal Failure, 24a. Wes an autopsy performed? Disease, Depression. Chronichung 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitat. 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 | Yes 2 | 1√10 this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? After 5 Pending investigation after deeth.

Director: Aft
d in by the fur 1 ∏Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital of within 24 hours of To the Funeral Di compietaly filled is 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifie 2/25/89 D31001 30

State

21215-0020

Baltlmore, Maryland

Box 68760.

P.0.

of Vital Records,

Division

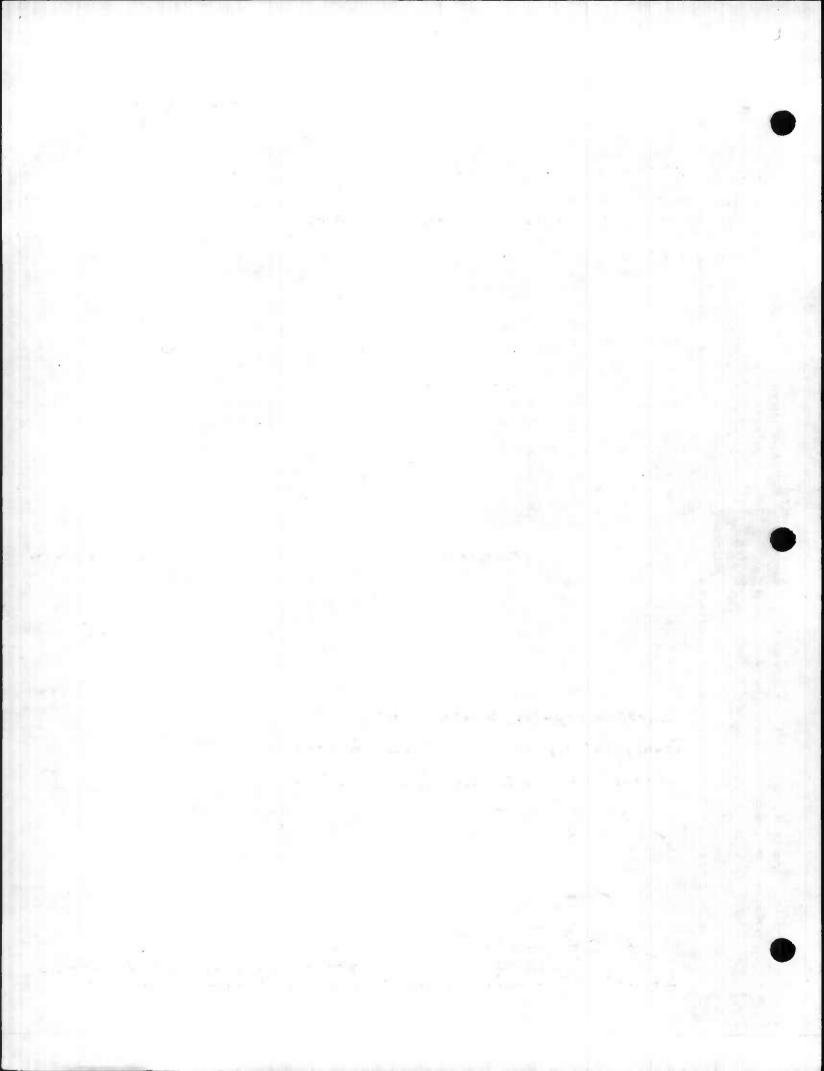
Registrar MAR 0 1 199

31. Date filed (Month, Day,

32. Registrar's Signeture

Spalls 20970.

Carbon of death (Hem 23a) (Type, Print) 7500 Greenway Cat. Dr. #430



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Month MARCH 2, 1999 **UMSTEAD** 4:58 AM BETTY ANN 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Dey, Year) Birthplace (Stata or Foreign Country) Days Months 1□ M 2□ F Yrs. July 26, 1934 Maryland Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Montgomery Kensington 10f. Zip Code 10g. Citizen of What Country? 3512 Decatur Avenue 20895 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 ☒No If Yas, Giva 1 Nevar Married 2 Married 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 □ Divorced Year or Datas: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Housewife Own Home 17. Fathar's Nema (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) Norris Mary Ellen Thomas 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) 3512 Decatur Avenue, Kensington, MD Ralph Umstead, Son 20b. Place of Disposition (Nama of cemetary, crematory or other place) Data 20c. Location - City or Town, Stata March 5 1 N Buylal 2 □ Cramation 3 □ Raproval from Stata 4 Donation 5 □Othar (Specify) Gate of Heaven Cemetery 1999 Silver Spring, Maryland of Funeral Sarvice Licenses 22. Nama and Addrass of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD 20877 n. 23a. Part/ Entar tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARDIAC ARRHYTHMIA **FEW HOURS** Due to (or as a consequence of): ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): Dua to (or as a consequence of): th?

Physician /Medical Examiner

physician and the burial-transit

signed by the at 1 be detached for

this

24 hours after death.

Funeral Director: A filled in

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Hospital

The law requires that the death certificate be executed

Records, P.O. Box 68760.

Division of Vital or Attending Physician:

parmit. Pages 1 and 2 should be fit Department of Health and Mental Hy Important. If them 27 is marked othly any Injury or other traumatic event

Physician

/Medical

Examiner

Funeral

Director

28a-f

Berns 23a or

filed within 72 hours after

altimore, Maryland 21215-0020

5. Social Security Number

220-32-5759

Maryland

10e. Street and Number

10a. Stata

Directo

Funeral

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Tommy

21. Signatura

20a. Mathod of Disposition

time

Examiner Physician/Medical þ Completed Be Certification: To

Sequentially list conditions, if any, laading to immediata causa. Enter Underlying Cause (Disease or Injury that initiated avants resulting In death) Last

Immediata Causa (Final disaasa or condition resulting in daath)

CORONARY ARTERY	DISEASE	23b. Did tobacco use contribute to the cause of 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Un				
		24e. Was en eutopsy performed?	24b. Ware autopsy findings available prior to completion of cause of death?			
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. Wes case refarred to medical	28. Place of D	Peeth (Check only one)				
axaminar? 1 ☐ Yas 2 🕱 No	Hospital: 1 ☐ Inpatient 2 ■ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing	Homa 5 ☐ Rasidence 6 ☐ Oth	ner (Specify)			

25. Wes case refarred to medical axaminar? 1 Yas 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	000	eth (Check only one) Homa `5 □ Rasidence 6 □ Other (Specify)
27. Menner of Death 1 Neturel 5 □ Pending 2 □ Accident invastigation	28a. Dete of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M t Yas 2 No	28d. Describe how injury occurred
3 Suicida 6 Could not b 4 Homicide		et, factory, office	28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one)	1 ★ Certifying Physician: To the best of my knowled 2 ★ Medical Examiner: On the basis of axamination and mannar stated.	ige, death occurred at the time, data and place, end dua to and/or investigation, in my opinion, death occurred at the	o the cause(s) end menner as stated. ima, date and place, and due to the
29b. Signatura and	d titla of certifiar	29c. License number	29d. Data signed (Month, Day,

tima, date and place, and due to the cause(s) 29d. Data signed (Month, Day, Year)

D005 2931

03,1999

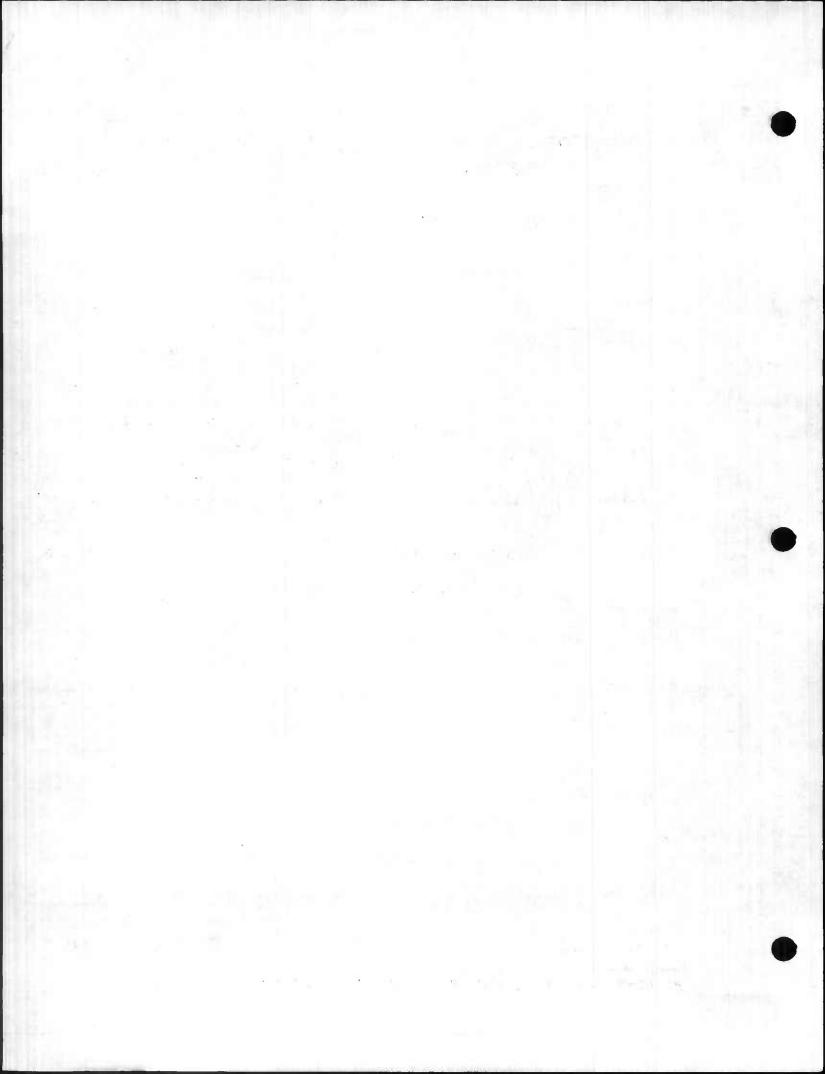
MARCH

Al Jamed, beggs, M.D 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

AL JAWAD WAQAS, M.D., 11119 ROCKVILLE PIKE, SUITE #100 ROCKVILLE, MD

State Registra

31. Data filed (Month, Day, Year) MAR 05 32. Registrar's Signatura



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death 28 Dey Month 1 da Jose 0927 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Spring KOSPIY Silver MonTromery Cr045 Holy If Under 1 Year | If Under 24 Hrs. 8. Dafe of Birth Months Days | Hours | Min. | FEB. 9, 1 6. Sex 14 M 2 ☐ F 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Months ARIZONA Yrs. 1936 527-44-0752 63 Usuel Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location MONTGOMERY SILVER SPRING 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20901 USA 310 OPERA COURT 12. Wes Decedent Ever in U,S. Armed Forces?

12 Yes 2 No H Yes, Give Year or Detes: 1962 Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11 Marital Status 1 Never Married 2 Merried Specify: WHITE 1 □Xyes 2 □ No Specify: MEXICAN 3 ☐ Widowed 4 ☐ Divorced 1962 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 5+ **PSYCHOLOGIST** MEDICINE 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) CARLOS VIDAL ELVIRA BORBOUN 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) LINDA BROWN-VIDAL (SPOUSE) 310 OPERA COURT SILVER SPRING, MD 20901 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON NATIONAL CEM. 3-8-99 ARLINGTON, VIRGINIA 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility HINES-RINALDI 11800 NEW HAMPSHIRE AVENUR SILVER SPRING, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Finel disease or condition resulting in deeth) Tenglor 196 Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of): Due to (or es a consequence of) Pert II. Other elanificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evailable prior to 24a. Was en autopsy performed? completion of cause of death? 1 Yes 2 No 1 □ Yes 2 □ No 26. Place of Deeth (Check only one)

Physician /Medical Examiner that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Nems 23s or

natural, or

I Hyglena.

permit. Pages 1 and 2 should be file.
Department of Heelth and Mental Hy important: If from 27 is marked offs, any injury or other traumatic event, once.

death

filed within 72 hours after

Baltimore, Maryland 21215-0020

Box 68760

P.O.

Records,

Division of Vital or Attending Physician: MD

Director

Funeral

þ

Completed

12

the Medical Examiner must be notified at

Examiner physicien and the burial-transit Physician/Medical 950 been signed by the should be detached þ Completed Be Certification: To this After n 24 hours after deeth.

ne Funeral Director: After colletely filled in by the fur

25. Wes case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ FVOutpatient 3 ☐ DOA 27. Menner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 1 Netural 5 Pending investigation 1 | Yes 2 | No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier ick only

29c. License number

1000428

within 2 To the

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. BRECHER, M DMK

metical Park Di mo

29d. Date signed (Month, Dey, Year)

Se6 28, 1999

State Registrar

edicai

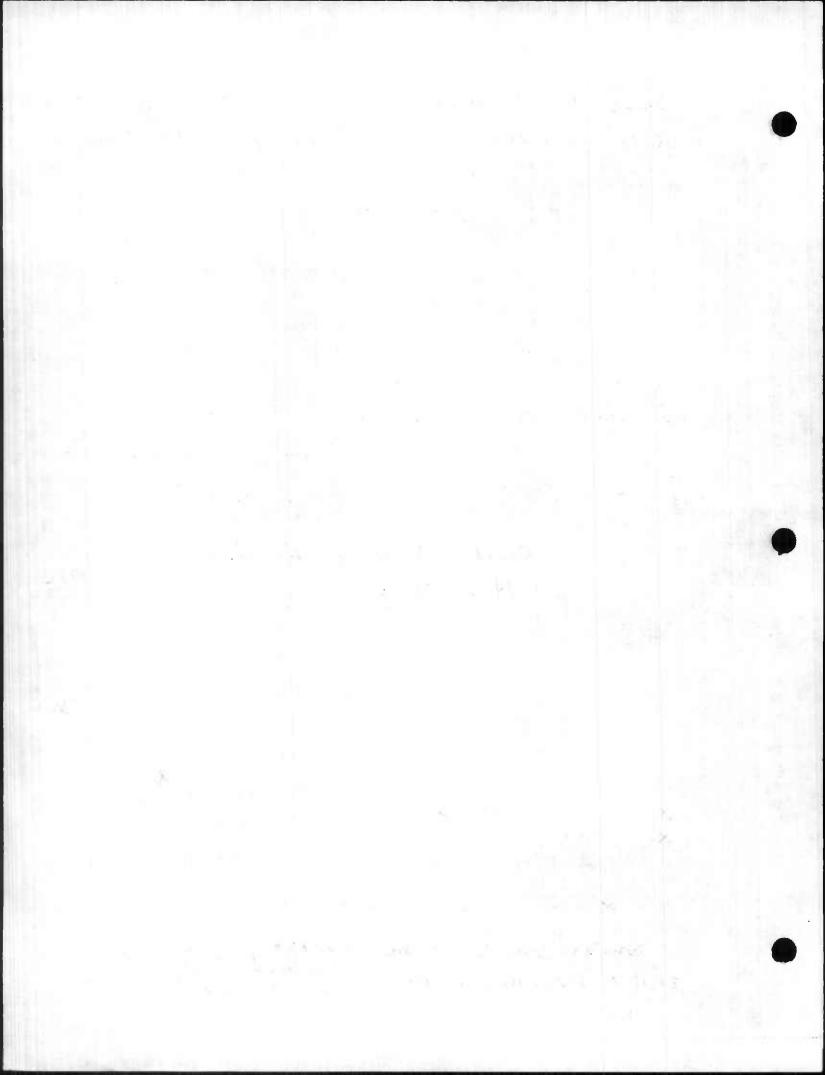
29b. Signal

no and title of certifier

31. Date filed (Month, Dey, Year) WAR 03

32. Registrar's Signature

DME



			Certificate	of Death		F	leg. No.		8599
1. Decedant's Nama (First, Middla, Las	()					2. Data of Dea	ith	Manage	3. Tima of Deati
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4a Facility Nama (If not institution, giva				4b. City, To		cation of Death		ty of Death	
SUBURBAN HOSPITAL	_			BETHE			MONTO	OMERY	Y
5. Social Security Number 6. Sa	7. Aga (I	In yrs. last birth	Months I	Year If Undar Days Hours	24 Hrs. Min.	8. Data of Birtl (Month, Da)	, Year)	9. Birth	place (Stata or Fore
5/8 38 552/ Usual Rasidance of Dacedant	8	б	rs.			SEPT 30	1912		INGTON D.
10a. Stata 10b. County N/A N/A	10	Oc. City, Town	or Location	С.					10d. Insida City Lin 1 ∏ Yas 2 □
10e. Street and Number			10f. Zip C	oda			10g. Citizan of	What Cou	intry?
4445 SEDGWICK STR	REET.N.W.			20016		20	Ţ	JSA	
11. Marital Status	12. Was Decedant Eva	ar in U,S.	13. Was Decedar		gin? (Spi	ecity Yas or No-	14. Ra	ce - Amari	ican Indian,
1 Nevar Married 2 Married 3 Vidowed 4 Divorced	Armed Forcas? 1 ☐ Yas 27 No If Yas, Giva Yaar or Datas:		1 ☐ Yas 2√		i, Fuarto	riican, atc.)		ack, Whita, ify:WHI]	
15. Decedant's Ed		16a. C	Decedant's Usual (Occupation			16b. Kind of I	Businass/In	ndustry
(Specify only highast grad Elemantary/Secondary (0-12)	da complatad) Collega (1-4or 5+)		Giva kind of work lifa. DO NOT usa	dona dunng mos ratired)	r or work	ing			
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17. Fathar's Nama (First, Middla, Last)				18. Motha	ar's Nama	a (First, Middla,	Maiden Suma	ıma)	
ZALMON DESKIN				JENN:	EE	UNI	KNOMN		
19a. Informant's Name/Ralationship (7			Mailing Addrass (S						
STANFORD B. WEINST			009 CONGR		COI	JRT POTO			
20a. Mathod of Disposition 1 ★ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	Primoval from State	cematary	Disposition (Nama , cramatory or other RAEL CEM	ar placa)	2	Data /24/99 V	20c. Location		
21. Signature of Funeral Service Licen		110110 10	1	Addrass of Facilit			TIDUITIO	,101-	D. 0.
The same	\ ./. \	4		KY GOLDI					
to come	Xuo	cu-	1170 RO	CKVILLE	PIK	E ROCKV	ILLE, MA	RYLAN	VD 20852
23a. Part 1. Enter the disaasa, or comp shock, or hear failura. List only of	olications that caused the ona causa on each lina.	a daath. Do no	ot antar tha moda	of dying, such as	cardiac	or raspiratory ar	rast,		
								i	Approximata Interval Batweer
Immadiata Causa (Final disaasa or condition	CARDIAC								Intarval Batween
	a	ARREST	onsaquance of):					1	Intarval Batween Onset and Death
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State Registrar

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglena. Important: If item 27 is marked other than "natural", or flems 23a or 28a-f show any injury or other traumatic event, the Medical Examinating the multiple notified as one

Physician /Medical **Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be axecuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and complately filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

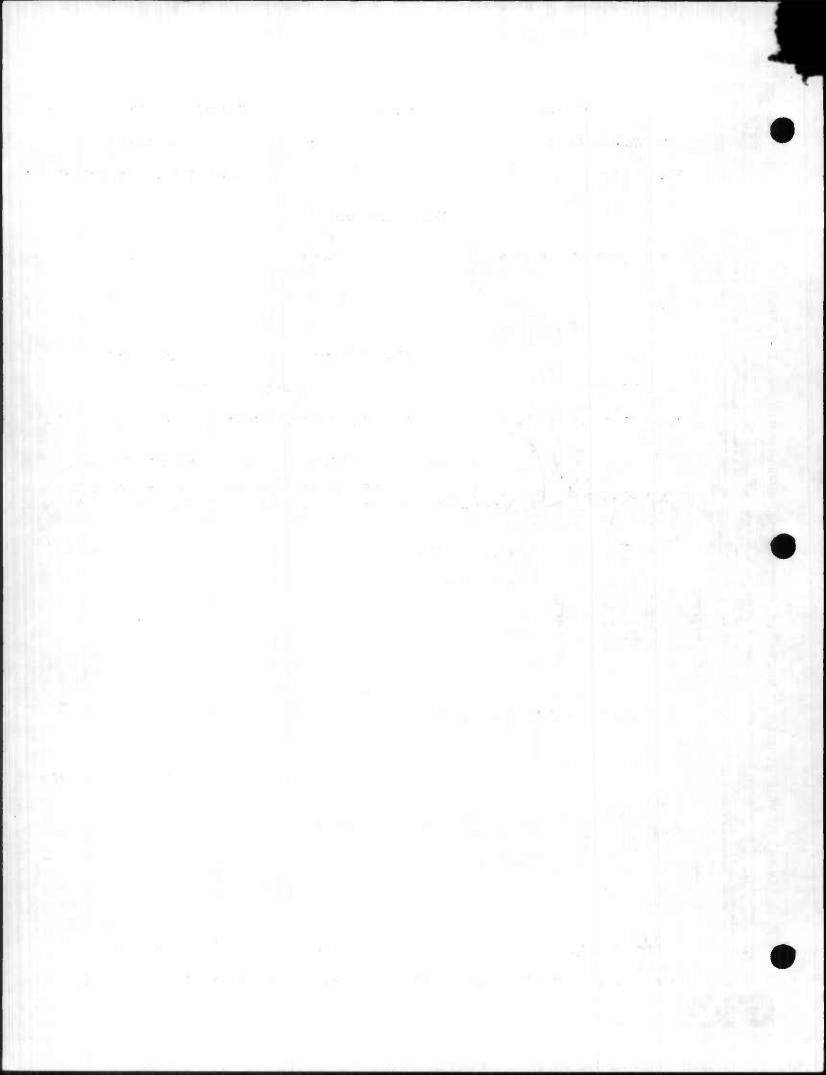
Baltimore, Maryland 21215-0020

31. Data filed (Month, Day, Year)

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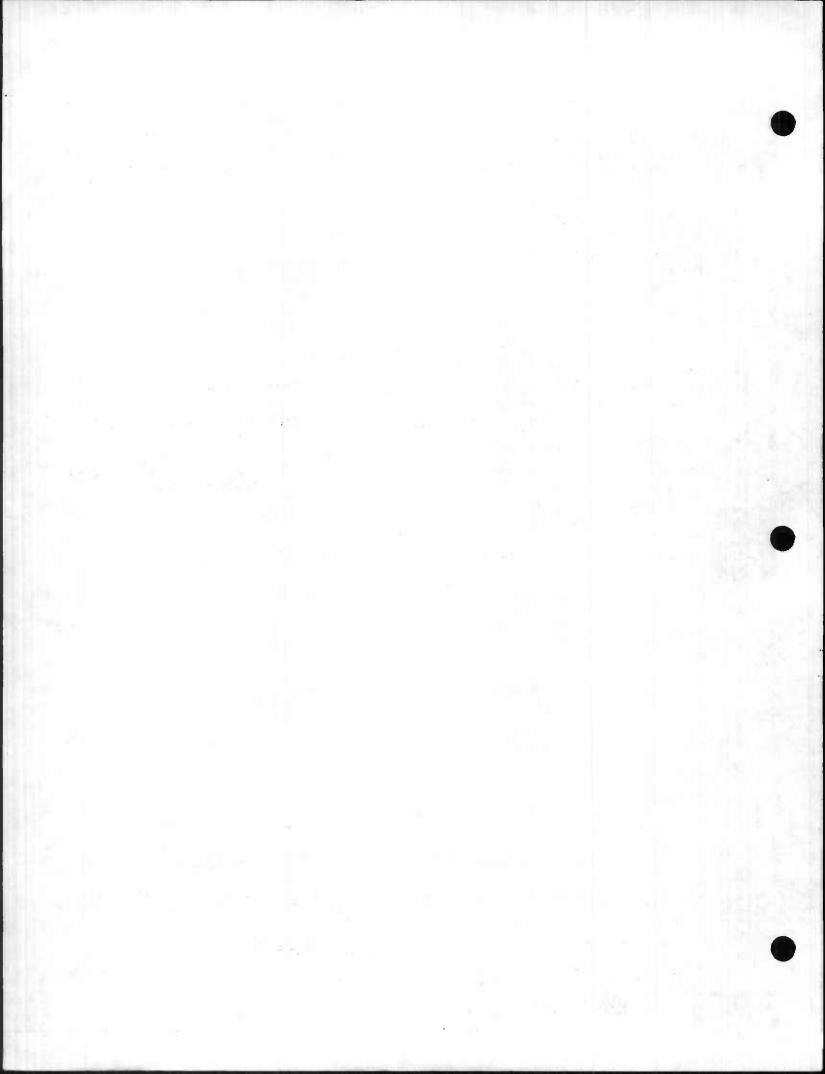
32. Ragistrar's Signatura

Sparks



State of Maryland / Department of Health and Mental Hygiene Q Q 08600

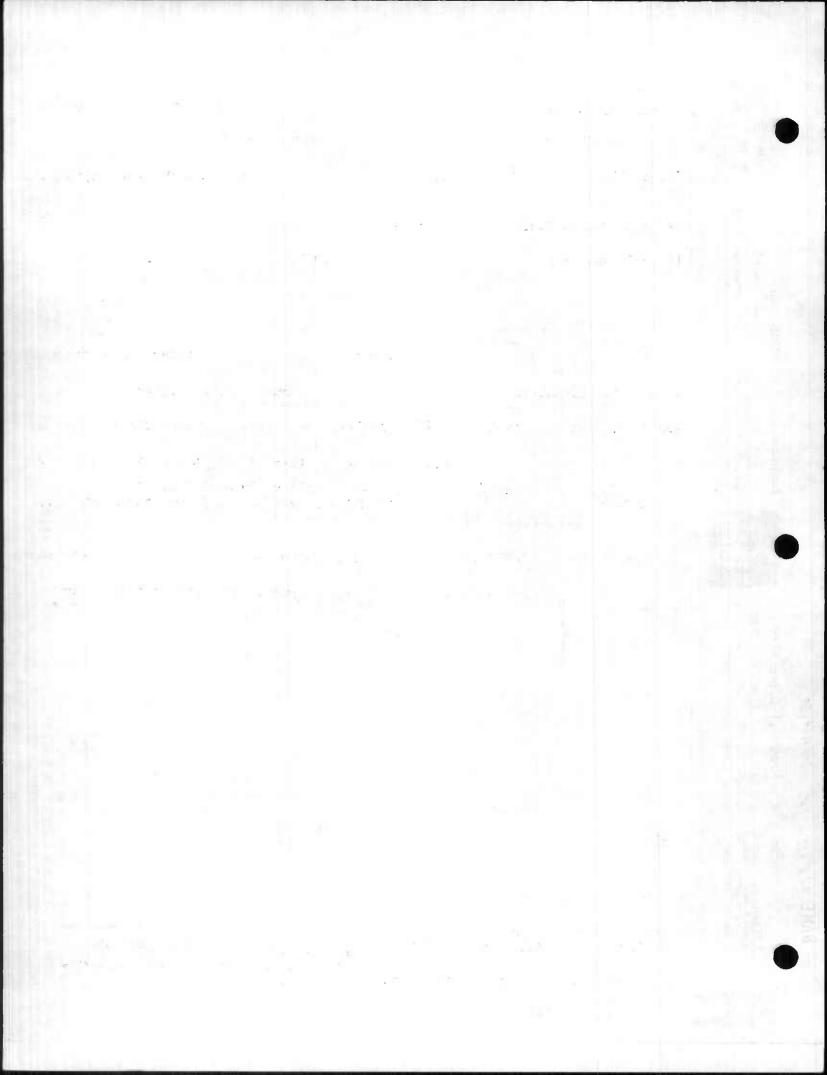
				Certifica	te of	Death		Reg. No.	100	
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/Medical	Mae Fayrine Wa	lker					Februar		999	7:50 AM
Examiner	4a Facility Nama (If not institution, g					4b. City, Town, or	Location of Death	4c. County	of Death	
	Montgomery Gene					01ney			ntgomer	-
Funeral Director	5. Social Security Number 401–12–8462 Usual Rasidance of Decedent	Sax 7. Ag	a (In yrs. last birtl	rs. If Und	er 1 Yaar s Days	If Under 24 Hr. Hours Mir		, Year) , 1916	9. Birthplace Country) Kentuc	(State or Foreign ky
P	10a. Stata 10b. County		10c. City, Town	or Location					10d. le	nside City Limits
with the Maryland as or 28s-f show the notified at Director	MD Montgo	mery	Rockv	ille					1	☐ Yes 2 No
vith the Ma t or 28e-f a be notified Director	10e. Street and Number	<u> </u>		10f. 2	Ip Code			10g. Citizen of V	What Country?	
at b	13116 Dumbarton	Drive			2	0853			USA	
72 hours after death with the Marylar natural, or items 23s or 28s-f show dical Examiner must be notified at sted by Furneral Director	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant Armed Forcas? 1 Yas 2 If Yas, Giva Yaar or Datas:				Hispanic Origin? (ean, Mexican, Pua Specify:	Specify Yas or No- rto Rican, atc.)	Specify	e-Amarican Inck, Whita, atc. " White	
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th. Pages rtment of rtsent: If its njury or o	12 Burial 2 Cramation 3 4 Donation 5 Other (Spec		Parkla	y, crematory or wn Memo	rotherpla orial	Park	3/3/99	Rockvil	le, MD	
Depart Import any in	21. Signature of Funeral Sarvice Lic	tron I		Home,	Inc.		ancis J. iversity 20901			al
Physician /Medical	23a. Part 1. Entar tha disaasa, or co shock, or heart failura. List on Immediata Causa (Final							rast,	Ons	proximata rval Between set and Death
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State of Maryland / Department of Health and Mental Hygiene

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NAME HELEN & WAITER



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Ethel Mary Wood February 23, 1999 10:15 PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Collingswood Nursing & Rehabilitation | Rockville Montgomery
9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1□M 2☑F Director 109-18-6610 England July 20, 1910 Usual Residence of Deceden the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified 1 ☐ Yes 2 ☑ No Director 28a-f Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Вети 23а 299 Hurley Avenue Funeral USA 14. Race - American Indian, 20850 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Datas; 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 Never Merried 2 N Merried Baltimore, Maryland 21215-0020 'natural', or 1 Yes 27 No Specify Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elamantary/Secondary (0-12) College (1-4or 5+) pormit. Pages 1 and 2 should be lies.
Department of Health and Mental Hyg.
Important: If them 27 is marked other any injury or other trainment. Homemaker Own Home 17. Fether's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Ephraim Atkinson Ethel Crompton 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 10713 Deborah Drive Charles P. Wood (husband) Potomac, Maryland 20b. Plece of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Mathod of Disposition Date 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 02/27/99 Alexandria, Virginia 21. Signature # Funeral Service License 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 ficetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, na cause on each line. Approximeta Intarval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examine physicien end the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immedieta cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of): 88 950 P.O. Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was an eutopsy performed? certificate has b lirector, page 2 s 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital 25. Wes case rafarred to medical examinar? Certification: To Be 26. Place of Death (Check only ona) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residance 6 Othar (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Naturel or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No r death. 2 Accidant 24 hours after deat Funeral Director: 6 Could not be datarmined 3 ☐ Suiclda 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) filled in by 4 Homicide Descripting Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29e. Certifier edicai (Check only one) within 2 the 29b. Signature and title of certified 29c. License number 29d. Data signed (Month, Day, Year) D 4595 10 30. Name and address of preservatio complated cause of death (Item 23a) (Type, Print)

State Registrar Wagad Attia, M.D.

31. Deta filed (Month, Day, Year) MAR 0 1

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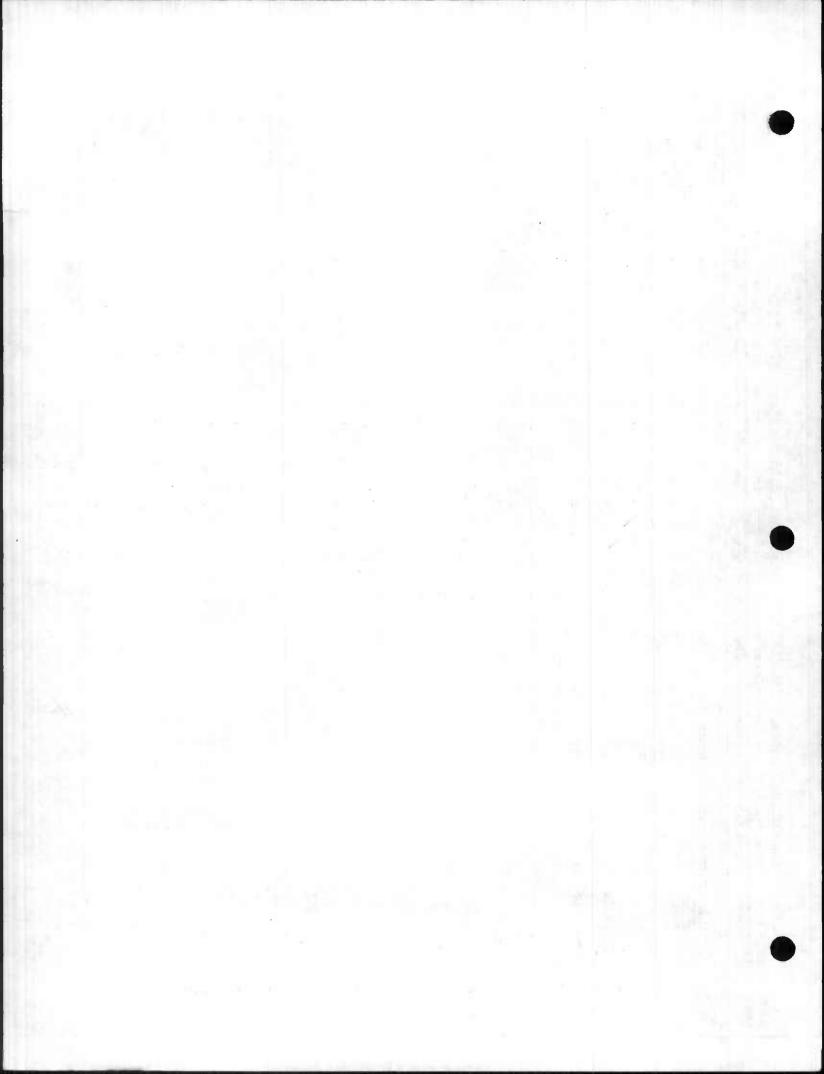
Frederick Avenue #230 Gaithersburg, Maryland 20877

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32. Registrer's Signeture

Deneva



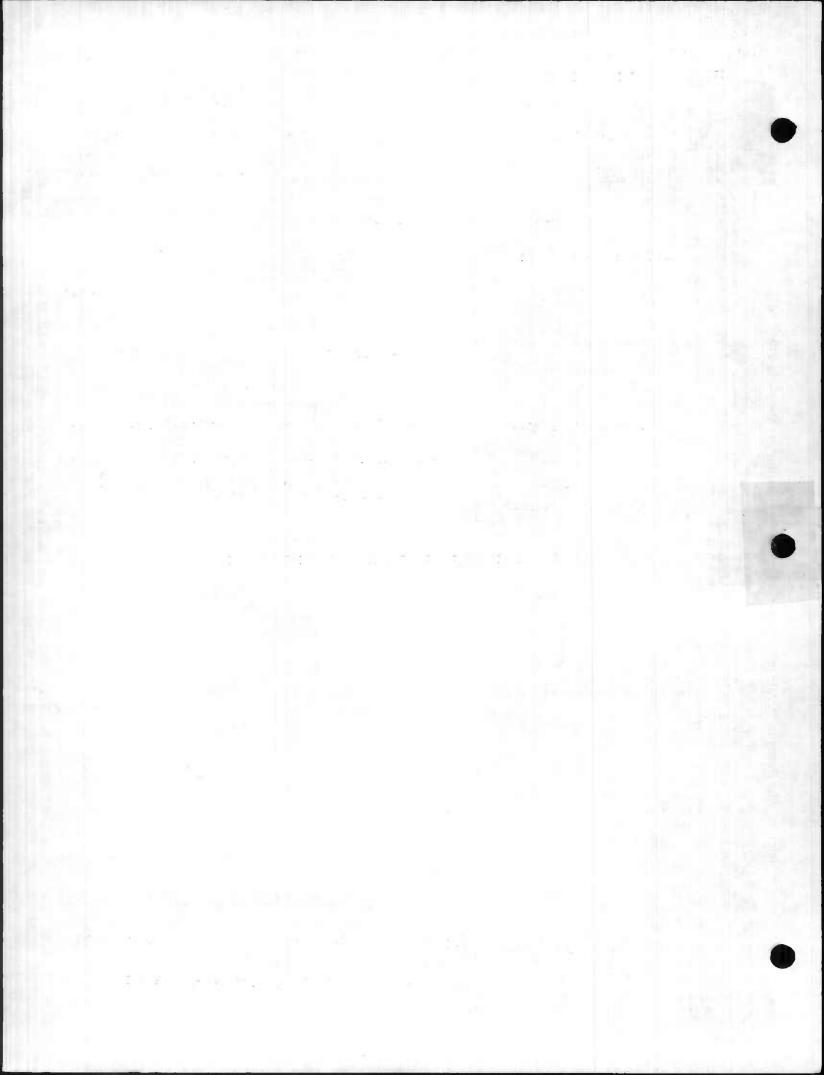
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Tr. Father's Name (First, Middle, Last) Filliott Eccard 19a. Informant's Name/Relationship (Type, Print) Filliott Eccard/Father 2903 Henderson Ave., Silver Spring, MD 2005 Filliott Eccard/Father 2904 Henderson Ave., Silver Spring, MD 2005 Filliott Eccard/Father 20a. Method of Disposition 12 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Filliott Eccard/Father 20b. Place of Disposition (Neme of camelery, crematory or other place) Gate of Heaven Cemetery 3/1/99 Silver Spring, MD 2001 21. Signature of Funeral Service Licensee Physician (Medical Examiner) 22a. Parti. Inter the disease, or complications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the death of the disease or condition resulting in death) Due to (or as a consequence of):	stry
17. Father's Name (First, Middle, Last) Elliott Eccard Joan M. Rosinski 19a. Informant's Name/Relationship (Type, Print) Elliott Eccard/Father 2903 Henderson Ave., Silver Spring, MD 2005 Elliott Eccard/Father 2904 Henderson Ave., Silver Spring, MD 2005 Elliott Eccard/Father 2905 Henderson Ave., Silver Spring, MD 2005 Elliott Eccard/Father 2906 Henderson Ave., Silver Spring, MD 2005 Elliott Eccard/Father 2908 Henderson Ave., Silver Spring, MD 2005 Elliott Eccard/Father 2908 Henderson Ave., Silver Spring, MD 2005 Elliott Eccard/Father 2908 Henderson Ave., Silver Spring, MD 2005 Elliott Eccard/Father 2908 Henderson Ave., Silver Spring, MD 2005 Elliott Eccard/Father 2908 Henderson Ave., Silver Spring, MD 2005 Elliott Eccard/Father 2908 Henderson Ave., Silver Spring, MD 2005 Elliott Eccard/Father 2908 Henderson Ave., Silver Spring, MD 2005 Elliott Eccard/Father 2908 Henderson Ave., Silver Spring, MD 2005 Elliott Eccard/Father 2908 Henderson Ave., Silver Spring, MD 2005 Elliott Eccard/Father 2908 Henderson Ave., Silver Spring, MD 2005 Elliott Eccard/Father 2908 Henderson Ave., Silver Spring, MD 2005 Elliott Eccard/Father 2908 Henderson Ave., Silver Spring, MD 2005 Elliott Eccard/Father 2908 Henderson Ave., Silver Spring, MD 2005 Elliott Eccard/Father 2908 Henderson Ave., Silver Spring, MD 2005 Elliott Eccard/Father 2908 Henderson Ave., Silver Spring, MD 2005 Elliott Eccard/Father 2908 Henderson Ave., Silver Spring, MD 2005 Elliott Eccard/Father 2908 Henderson Ave., Silver Spring, MD 2005 Elliott Eccard/Father 2908 Henderson Ave., Silver Spring, MD 2005 Elliott Eccard/Father 2908 Henderson Ave., Silver Spring, MD 2005 Elliott Eccard/Father 2908 Henderson Ave., Silver Spring, MD 2005 Elliott Eccard/Father 2908 Henderson Ave., Silver Spring, MD 2005 Elliott Eccard/Father 2908 Henderson Ave., Silver Spring, MD 2005 Elliott Eccard/Father 2908 Henderson Ave., Silver Spring, MD 2005 Elliott Eccard/Father 2908 Henderson Ave., Silver Spring, MD 2005 Elliott Eccard/Fa	
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Duiting, etc. (Specify) 29a. Certifier (Check only one) 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month. Date)	

29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of confifier O.C.M.E FEB. 25, 1999

30. Name and dress of person who completed cause of deeth (Item 23e) (Type, Print)

Joseph Pes Tower 111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Morith, Dey, Year)
MAR 0 1 1999 32. Registrar's Signature



Box 68760, Division of Vital Records, P.O.

1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth ARCHIE JOHNNIE WHEELESS **Physician** Month Dev Lupacles s Johnnie -4 March 1 1999 0725 /Medical 4a. Fecility Nema (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Sociel Security Number 6. Sex 1 M M 2 ☐ F 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthpleca (State or Foreign Country) **Funeral** 213-28-5886 Director 74 Dec.31,1924 North Carolina Usuei Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show 1 X Yes 2 □ No Director Worcester Maryland 3825 Market Street, Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3825 Market Street 21863 USA Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, etc.) 14. Reca - Amarican Indien, Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1944 -1946 1 Never Merriad 2 Married 1 Yes 2 No Completed by Specify: 3 Widowed 4 Divorcad **Black** traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementery/Secondery (0-12) College (1-4or 5+) Hygiene. 10 Line-worker Currogated Factory 17. Fathar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be 1 ant of Health and Mental Robert Wheeless Ednar 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Department of Health e Important: if item 27 is any injury or other tra Annie Wheeless (wife) 3825 Market Street, Snow Hill, Maryland 21863 20a. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cremetery or other piece) Dete 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremation 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) Jones' Hill Baptist Cem. 3/9/99 Spring Hope, N.C. 21. Signature of Funarel Sayon Licensee 22. Name end Address of Fecility Bennie Smith Funeral Home P.O.Box 331, Pocomoke, Maryland 21851 23a. Pert1. Enter the disease, or cynolications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errest shock, or heart feilure. Landily one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Examiner Due to (or es e consequence of) or Attanding Physician: The law requires that the death certificate be executed effer death.

Director: After this certificate hes been signed by the ettending physician not in by the funded director, page 2 should be detached for use as the buriet-trensit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or as e consequence of): signed by the etter Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ Completed 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of causa of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical exemines? 26. Place of Deeth (Check only one) Hospital: ppatient 2 ER/Outpatient 3 DOA No. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 27 Manper of Deeth Certification: 28a. Deta of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Naturel 5 Pending investigetion 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicida 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours eft To the Funeral Di completely filled in 29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

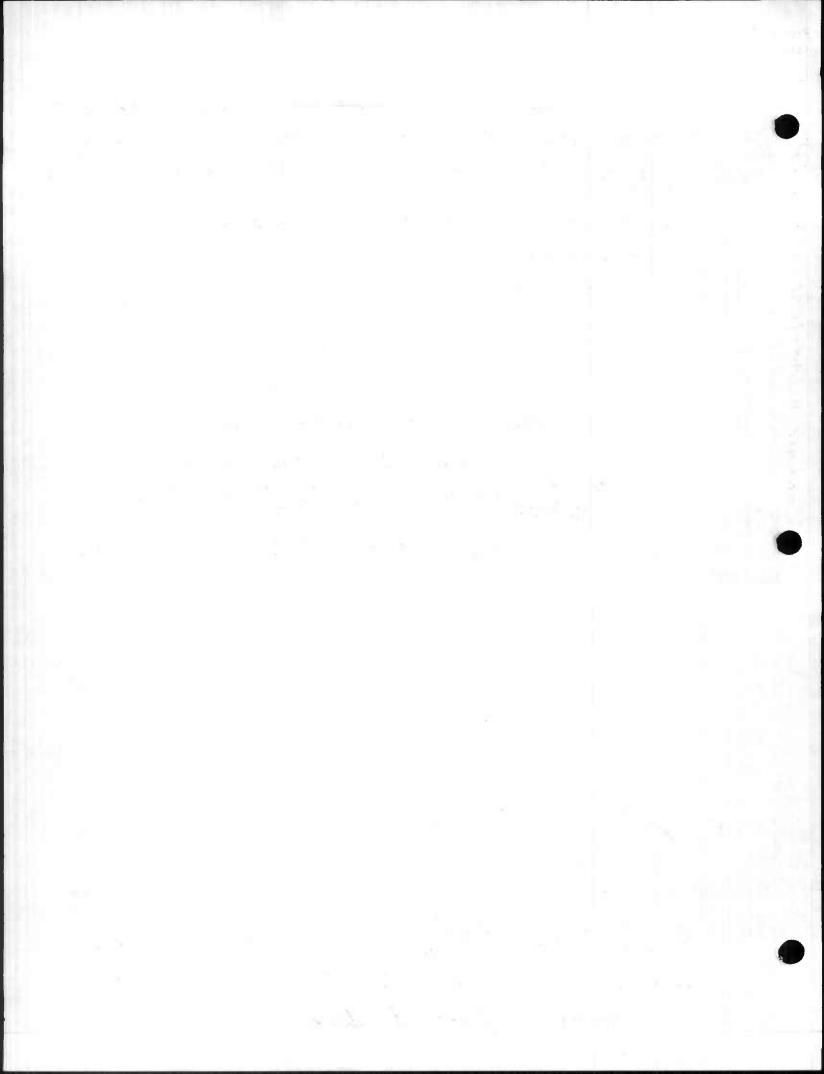
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29c. License number 29d. Date signed (Month, Day, Year) 0 76278 MIL) Neme end eddress of person who completed cause of death (Item 23e) (Type, Print) Salish, MD Court. MAD E. Carroll St. 145 32. Registrer's Signeture State Registrar **DHMH 16 Rev 6/95**

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

AMEND#1 PER MD. G782 4-20-2000 JAB



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 🔾 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Charles Thomas 0541 AM PARCH /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Fallston General Hospital Fallston Harford If Under 1 Yeer | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 11/21/36 7. Age (In yrs. last birthday). Birthpiace (State or Foreign Country) **Funeral** Director Pennsylvania Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits show r than "natural", or items 23s or 28s-1 show The Medical Examiner must be notified at 1 Yes 2 No Director Maryland Harford Forest Hill 10e. Streef and Number 10f. Zip Code 10g. Cifizen of What Country? 337 Bynum Road 21050 USA Funeral 12. Was Decedenf Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11. Merifel Status hours efter 1 ☐ Yes 2 No If Yes, Give 1 Never Married 20 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Auto Mechanic Automobile Repair trsumatic event, permit. Pages 1 end 2 should be file.
Department of Health end Mental. Hy
important: If them 27 is marked other
any injury or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Thomas Charles Wehry, Sr. Blanche Mildred Luke 19a. fnformant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly G. Wehry/ Wife 337 Bynum Road, Forest Hill, Maryland 21050 20c. Location - City or Town, State 20a Melhod of Disposition Date cemetery, crematory or other place) 1X Burial 2/C Cremation B Removal from State 5 Other (S St. Mary's Episcopal Chr. 3-4-99 Abingdon, Maryland Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Betwo Onset and De **Physician** /Medicai Immediate Cause (Final disease or condition resulting in deeth) **Examiner** Examiner siclan end burief-transit certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last physician s the burie P.O. Box 68760, Physician/Medical 98 significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? isigned by t 1 Yes 2 No 3 Probably 4 Unknown Records, by should I 24b. Were eutopsy findings available prior fo completion of cause 24e. Wes an autopsy Completed 1 Yes 2 No 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 2 1 Impatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: After Attending 1 Natural 5 Pending investigation deeth. 1 Yes 2 No 2 Accident or Attend efter deeth Director: 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 24 hours e Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medicai To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature as 29c. License number 16444 March 1st 1999 10 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) VIJAY - S. NAIR M.D. 2112 Roclain

State Registrar

31. Date filed (Month, Day, Yeer)

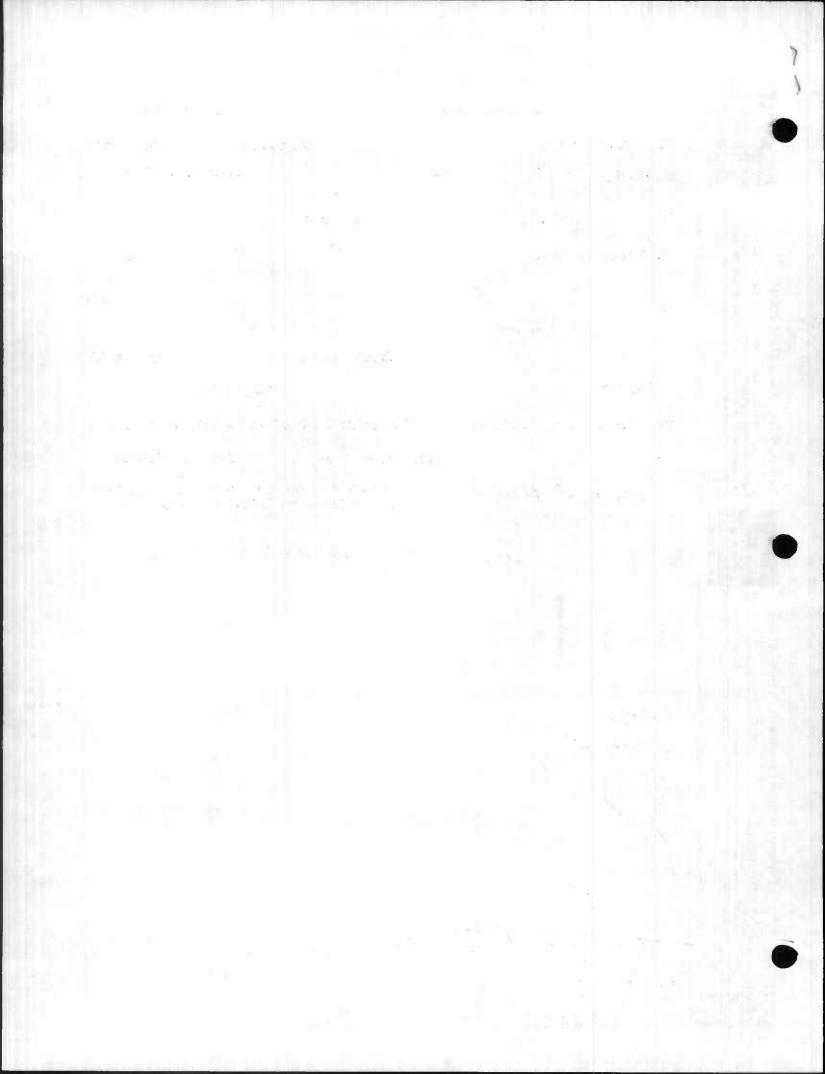
MAR 0 2 1999

32. Registrar's Signature

Road. Fallstan. MD 21047

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended Item 7, per F.D. State of Maryland / Department of Health and Mental Hygiene Q 3/4/99, Carroll County, wjl Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** 10:15 am 28, 1995 ath 4c. County of Deeth Charles White Feb. /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) Examiner 7809 Brevort Road Baltimore Baltimore If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1 N 2□ F Months Deys Hours Min 81 82 Yrs. June 6, 1917 Virginia Director 218-07-5289 Usuel Residence of Deceden with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Baltimore Directo Baltimore 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 21144 7809 Brevort Road USA Funeral death 14. Raca · American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: P Black 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry i Hygiena. Elementery/Secondery (0-12) College (1-4or 5+) permit. Pagas 1 and 2 should be filed v Department of Health and Mantal Hygien Important: if tem 27 le marked orther it any Injury or other traumatic event, 11st once. 8 Truck Driver Transportation 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Unknown Betsy White 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Mrs. Joan Hughes (Guardian) 4213 Huntshire Road Randallstown, MD 21133 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 3/3/99 Druid Ridge Cemetery Baltimore, MD 22. Name end Address of Fecility 21. Signeture of Funerel Service Ligensee HAIGHT FUNERAL HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400

23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Brian X . Harlet Approximete Intervel Between Onset end Deelh **Physician** acute misocuraial infraction Immediete Cause (Final diseese or condition resulting in death) /Medical **Examiner** Due to (or es e consequence of): Examiner attanding physician and for use as the bunal-transit cartificata be axecuted Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): usa as t 23b. Did tobacco use contribute to the cause of death? P.O. | ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown signed t Records, þ 24b. Were eutopsy findings eveileble prior to Smoker Completed 24e. Wes en eutopsy performed? completion of cause of deeth? paga 2 s has Alcohol Alouse 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 10 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: Aftar 1 Natural 5 Pending after death. 1 Yes 2 No Investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pieca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 3 4 Homicide 6 Hospital 24 hours 29e. Certifier 1 Detrifying Phyelcian: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) end manner es stated. edical complataly 2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end menner steted. (Check only one) within 2 To the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture end titte of certifier 30. Neme and eddress of person who completed cause of death (Hem 23e) (Type, Print) Smmons - Clemmons mD 1838 Greene Trees WAnder (31. Dete filed (Month, Day, Yeer) 32. Registrer's Signature State Registrar MAR 0 4 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Data of Deeth 3. Time of Deeth Month **Physician** Veer **VIRGINIA** S. WARD March 1999 1, 5:20 A. M. /Medicai 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 4042 Jacksonville Road Crisfield Somerset 5 Social Security Number If Undar 1 Yaar If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funerai** 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 1 1 F Yrs. 214-34-5596 Director 63 February 9, 1936 | Maryland Usual Residence of Decedent the Maryland 10a Stete 10h County 10c, City, Town or Location 10d. Inside City Limits 28a-f show must be notified at Maryland Somerset 1 ☐ Yes 2 No Crisfield Director 10e. Street end Number 10f. Zip Coda 10g. Citizen of Whet Country? 6 4042 Jacksonville Road 238 21817 U.S.A. Funeral Items 2 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indien, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2X No Specify: à Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Chesapeake Forest than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Products Secretary is marked other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Peges 1 and 2 should be Ralph R. Sommers Lucy Parks 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health elimportant: if Item 27 is any Injury or other trat once. Walter E. Ward, Jr. (Husband) 4042 Jacksonville Road - Crisfield, MD 21817 20b. Plece of Disposition (Neme of cemetary, crematory or other place) 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Sunnyridge Memorial Park 3/4/99 Crisfield, MD 4 Donetion 5 Other (Specify) 21. Signeture 22. Name end Address of Fecility Bradshaw & Sons Funeral Home H. Bradshaw, Robert 306 W. Main St.- Crisfield, MD 21817 23a. Part 1. Enter the disease, or complications that ceutar the death. Do not enter the mode of dying, such as cerdiac or respiretory errest shock, or heer failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medicai Immediate Cause (Final ENDOMETRIAL CANCER diseese or condition resulting in death) Examiner Due to (or es e consequence of) The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in deeth) Last Due to (or es e consequance of): Box 68760, Physician/Medical the Due to (or es e consequence of): 98 6 the Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 0 23b. Did tobecco use contribute to the cause of deeth? signed by the 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, P. þ 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? Completed peed ate has bage 2 s 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) 2 1 Yes 25 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Medicai Certification: After 5 Pending Investigation Injury 1 Nature deeth. 1 ∏ Yes 2 ∏ No 2 Accident Director: / 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide In 24 hour, the Funeral Directory Hospital 29a. Certifiar 🗺 Certifying Phyelclen: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the ceuse(s) and menner as stated. 2 Madical Exeminer: On the basis of axamination end/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) To the To the To the I end menner steted. 29b. Signetura and titla of certifiar 29c. Licansa number 29d. Date signed (Month, Day, Year)

State Registrar

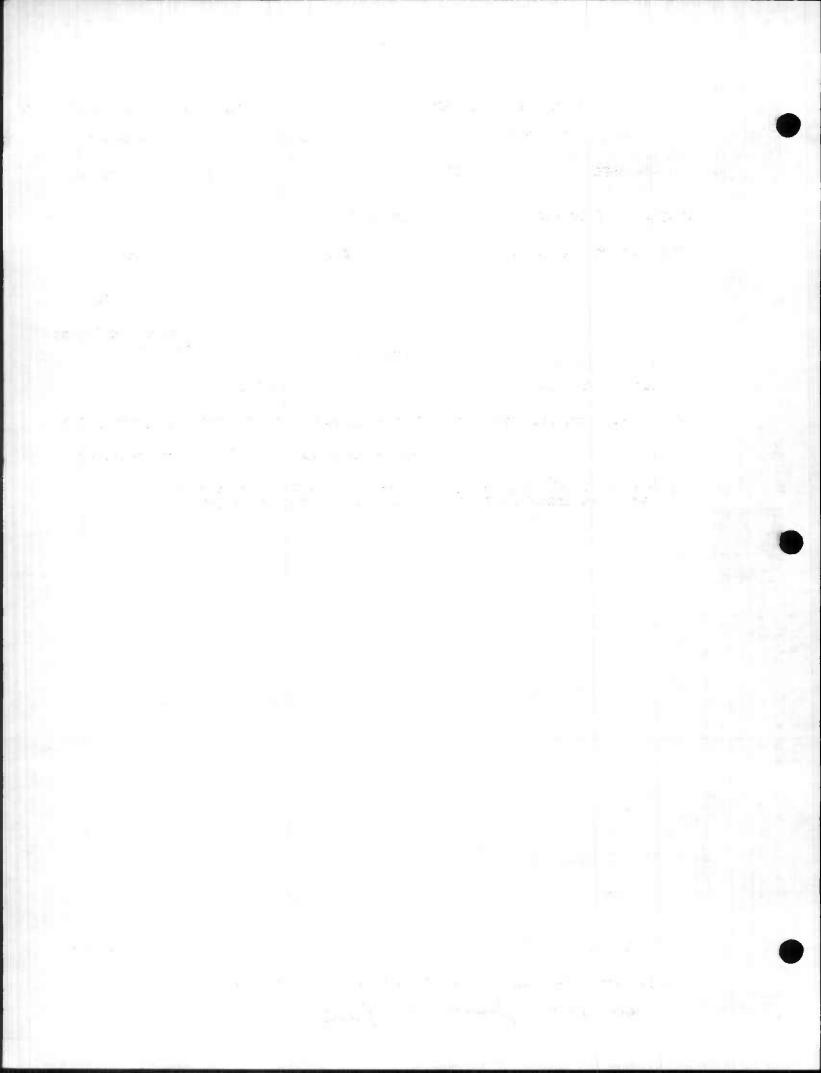
31. Dete filed (Month, Day, Year) MAR - 5 1999 32. Registrer's Signeture

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, MD 21817

D48098

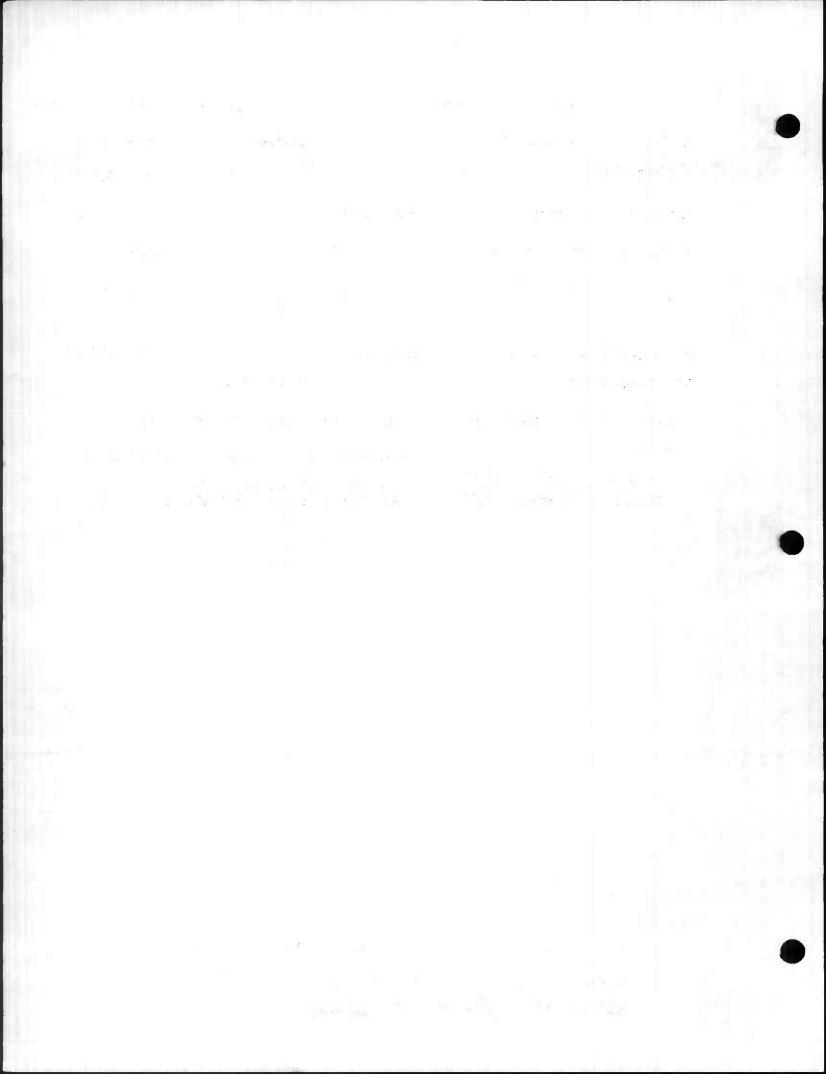
MARCH 2, 1999



State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month 28, February 1999 2:40 P.M. IDELLA F. WARD /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner 3 Village Drive- Apt. 18 Crisfield Somerset If Under 24 Hrs. Hours Min. 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Days 1□M 20 F Months Hours 230-14-1147 77 Yrs Director March 6, 1922 Maryland Usual Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show and Injury or other traumatic event, the Medical Examiner must be notified apones. Somerset Crisfield Maryland 1K Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21817 U.S.A. 3 Village Drive - Apt. 18 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by 3. Widowed 4 ☐ Divorced Completed 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Medical-Hospital H. S. Graduate 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be John Bennett Byrd Viola Ford 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 8 Hall Highway - Crisfield, MD Donna Wigglesworth (Daughter) 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremetlon 3 ☐ Removel from State Sunnyridge Memorial Park 3/3/99 Crisfield, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture 22. Neme and Address of Fecility Bradshaw & Sons Funeral Home reles Robert H. Bradshaw, 306 W. Main St. - Crisfield, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel ASCVD disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner Hospital or Attanding Physician: The law requires that the death certificete be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) physician a Box 68760. Physician/Medical Due to (or es e consequence of) ed by the a Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. n signed by ti 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by Completed 24b. Were eutopsy findings eveilable prior to 24e. Wes en eutopsy completion of ceuse of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical Be 26. Piece of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No funeral Certification: 27. Menner of Deeth 28e. Date of Injury (Month, Dev Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Natural 5 Pending 1 Yes 2 No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D completely filled Certifying Phyelclan: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner steted. Medical 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D 48098 MARCH 2, 1999 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) 201 Hall Highway - Crisfield, MD Vijay Karumbunathan, M. D. 31. Dete filed (Month, Dey, Yeer) MAR - 5 1999 32. Registrar's Signeture State oaks Registra

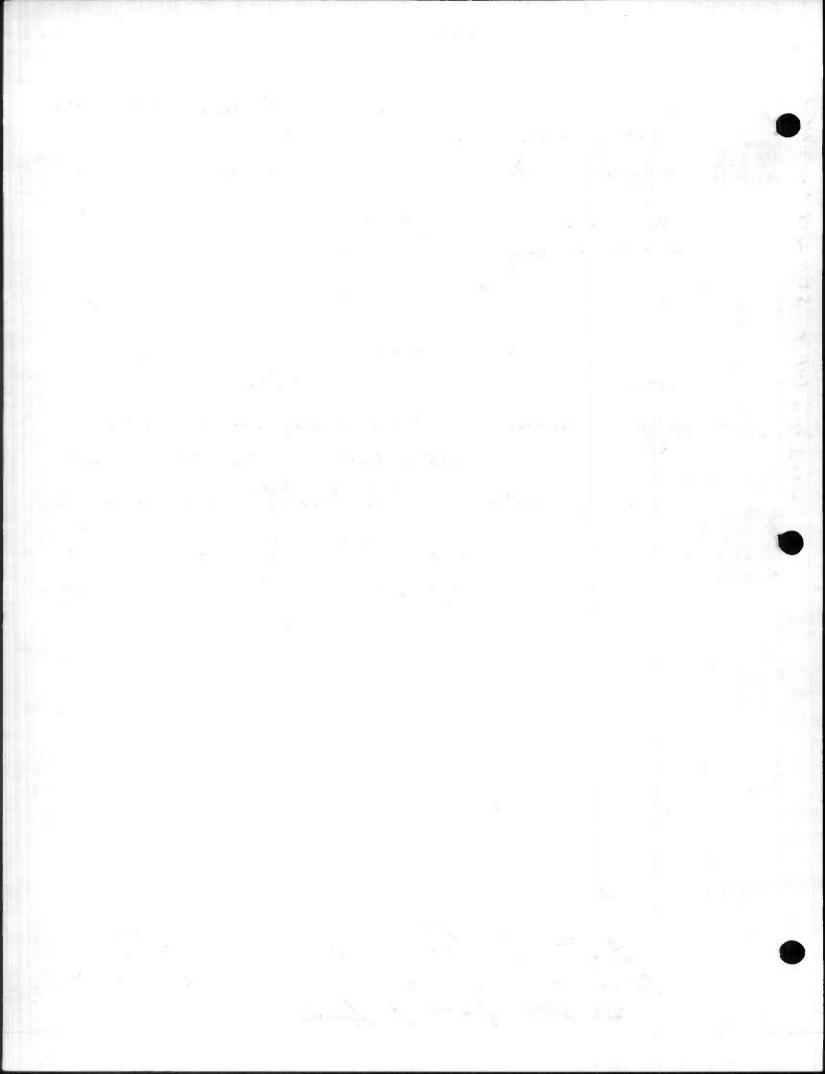


State of Maryland / Department of Health and Mental Hygiene ()

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 3 Tima of Deeth 2. Data of Death **Physician** March 1, 1999 VIRGINIA WHITT 0900 /Medical 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER 7. Aga (In yrs. last birthday) If Undar 1 Year If Under 24 Hrs. Birthpiece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F Months Days Hours Director 3/24/1913 219-03-5949 Maryland Usual Rasidence of Decedan with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits show event, the Medical Examiner must be notified at 1 Yes 2□ No Director 288-1 Maryland Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 415 South Camden Avenue 21826 USA 12. Was Dacedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indien, Black, Whita, atc. hours after 1 Navar Married 2 Married Maryland 21215-0020 1 ☐ Yas 2 No Specify. Completed by 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Dacadant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fethar's Nama (First, Middle, Last) 18. Mother's Nema (First, Middla, Maiden Sumema) Be should be ind Mental Andrew Dashiell Julia Ford 2 19a. Informant's Name/Relationship (Typa, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) . Pages 1 and 2 s ment of Health an .0 permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra Darlene Smack/Daughter 103 Woodcrest Ave., Salisbury, Md. 21804 20a. Mathod of Disposition

1 ■ Burial 2 □ Crametion 3 □ Ramoval from State 20b. Piaca of Disposition (Nama of cemetary, cramatory or other placa) 20c. Location - City or Town, Stata □ Donation 5 □ Othar (Specify) Beechwood Cemetery 3/3/99 Princess Anne, Md. Signatura of Funaral Sarvica Licensea 22. Nama and Address of Fecility Hinman Funeral Home 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Winner M00295 Princess Anne, Md. 21853 Approximete Interval Between Onsat end Death **Physician** Into Cerebril Bleeg /Medical Immediata Causa (Final disaasa or condition rasulting In death) **Examiner** Examiner 2043 Revensia The law requires that the deeth certificate be executed Sequantially list conditions, if eny, laading to immediate causa. Enter Underlying Causa (Diseasa or injury thet Initiated avants rasulting in death) Last and as a consequence of) Box 68760. ettending physician Physician/Medicai Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by t Id be datach 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Wera autopsy findings available prior to complation of causa of deeth? Completed 24a. Was an eutopsy performed? certificate has 1 🗆 Yas 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case raferred to madical axeminer? 26. Placa of Daath (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) P 1 Yas 2 No 1 Inpatiant 2 ER/Outpetient 3 DOA this 27. Menner of Death Date of injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Tima of 28d. Dascribe how Injury occurred After t 1 Natural 5 Panding Invastigation 1 ☐ Yes 2 ☐ No death. 2 Accidant in by the within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not ba 3 Suicida 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida Hospital 1 Certifying Physician: To the bast of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as stated.
2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Cartifiar ů, 29b. Signature and title of cartifier 29c. Licanse numbar 29d. Date signed (Month, Day, Year) 1 an un 30. Nama and addrass of person who completed causa of death (Item 23e) (Type, Print) Selly HOZE Reversal De BEN/10 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State 3 1999 MAR -Registrar

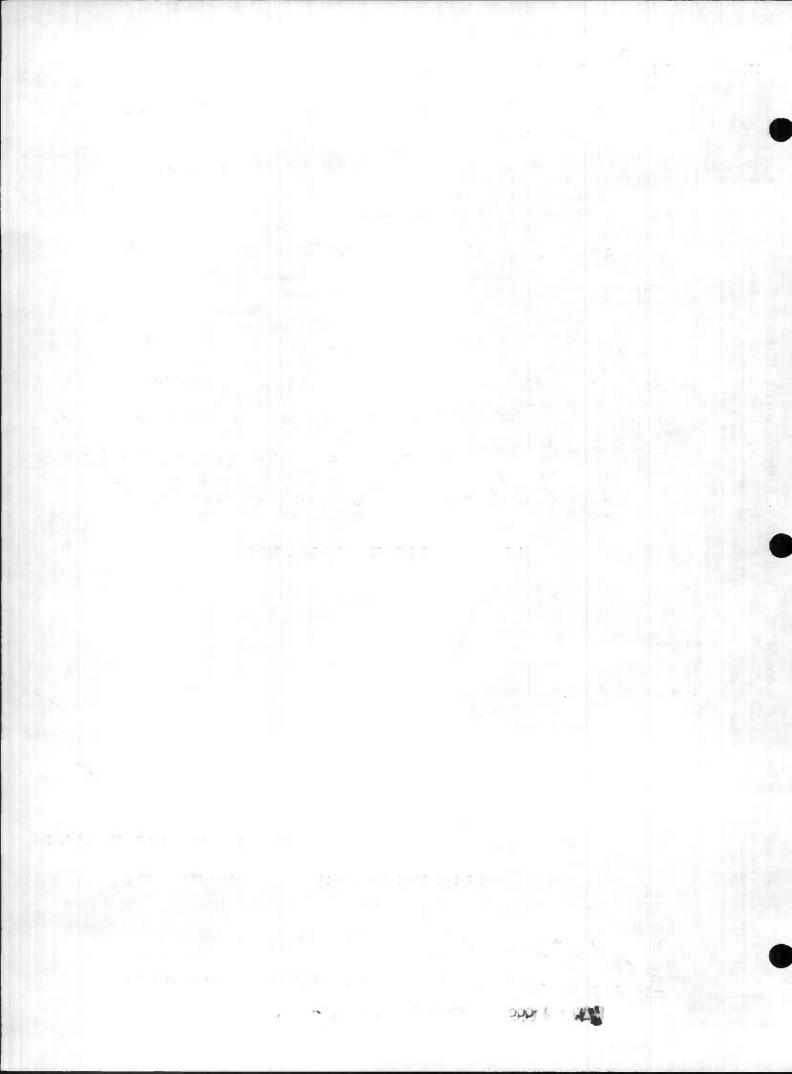
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TYRONE WILLIS (baby Craston)

State of Maryland / Department of Health and Mental Hygiene

•	PART I, 27, 28A-F PER 1. Decedent's Name (First, Middle, L	actl			2. Dete of Deet			of Deeth	
Physician /Medical	TYRONE	De ANDR		Dey 3, 1999		PM			
Examiner	4e Fecility Neme (If not institution, grund UNIVERSITY OF M		r Location of Death ORE 4c. County of Deeth BALTIMORE						
Funeral Director	5. Sociel Security Number 6.	Sex 1 M 2 F 7. Age (In yrs	7. Age (In yrs. lest birthday) Yrs. If Under 1 Year If Under 24 Hr Months Days Hours Mir						
ahow dat	Usuel Residence of Decedent 10e. State 10b. County MD, FREDE		ity, Town or Location			10d. fnside City Lim			
or 28a-f be notifie Directo	10e. Street end Number		TH ST, APT A 21701			Og. Citizen of W	/het Country?		
Maryland 21215-0020 d 2 should be filed within 72 hours after deeth with the Maryland th and Mental Hygiene. 7 is marked other than "natural", or hams 23s or 28s-f show traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	11. Meritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:		Specify Yes or No- nto Rican, etc.)	pecify Yes or No- to Rican, etc.) 14. Race - American Indian, Black, White, etc. BLACK/WHIT				
	15. Decedent's Elementery/Secondary (0-12)	Education rade completed) College (1-4or 5+)	16e. Decedent's Usual Occupation (Give kind of work done during most of the life. DO NOT use retired)				Kind of Business/Industry		
	17. Fethers Neme (First, Middle, Las	WILL15		18. Mother's No.	eme (First, Middle, M		e)		
alth and Menta 27 Is marked or r traumatic ev	19e. Informent's Name/Reletionship BARNEY WILLI			ess (Street end Number or F					
ient of Health nt: If Item 27 ry or other t	20e. Method of Disposition 1 Burial 2 Cremetion 3 4 Donetion 5 Other (Spec	20b. □Removel from Stete	Plece of Disposition (A cemetery, cremetory of OLIVET	r other place)	Dete R. 8, 1999		City or Town, Stele	no.	
Departmen Important: any Injury phos.	21. Signeture of Funerel Service Lice	Policies Conservation	1001	end Address of Fecility L. ROLLIN UEST SOUTH S	US FUNE	12AL H	tomt		
Physician /Medical Examiner Examiner Examiner	immediate Ceuse (Finel disease or condition resulting in death) Sequentially list conditions,	Due to (DMINISTRATION (or es a consequence of	L	DING				
g physicia as the bur edical	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet intitated events resulting in deeth) Last	cDue to (or es e consequence o	f):					
ached ached	Part ii. Other significant conditions	contributing to deeth but not re	sulting in the underlyin		obacco use cor as 2 No	atributa to the caus	of death		
has b					24e. Wes a perform	n eutopsy med?	24b. Were autops evelleble pric completion of of death?	or to	
actor Be	25. Wes case referred to medical examiner?	Hospitei:		Other:	eeth (Check only on				
Sign P	27. Menner of Deeth 1 Neturel 5 Pending	28e. Dete of Injury (Month, Dey Year)	28b. Time of fnjury	28c. injury et Work?	Home 5 ☐ Reside	ow injury occurr	ed		
rs aftar death. In Director: After the in by the funeral Certification:	2 Accident investigati 3 Suicide 6 Could not determine	on 3-3-99 be d 28e. Plece of injury - At I building, etc. (Spec	M 1 Vos 2 10 No			IMPROPER ADMINISTRATION OF FLUIDS 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) UNIVERSITY HOSPITAL			
Funera Funera stely fille	29e. Certifier 1 Cartifying F (Check only one)	Physician: To the best of my kn amfner: On the basis of exemin	owledge, death occurre	ed et the time, date end pled	ce, end due to the c	euse(s) end me	nner as steted.	e(s)	
Divisio To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fr	29b. Signeture end title of certifier	end menner steted.	2		d (Month, Dey, Year))			
	30. Neme end editress of person who	ann 11-1) -						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3/16/99 Item: 1 per M.D G-769 reb Certificate of Death 1. Decedent's Name (First, Middle, Last) Marlene Louise WISECARVER 2. Date of Death 3. Time of Death Month MILLENE FEBRUARY 16,1999 14:50P 4a Facility Name (If not institution, give street and number Sacred Heart Hosp. 4b. City, Town, or Location of Death Cumberland Allegany 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dev, Year) Months Min Days Hours 1 M 2 D Maryland July 6,1939 Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inaide City Limits 1 ☐ Yas 2 ☑ No Garrett Oakland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Mayhew Inn Road 21550 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indien. 11. Marital Status Bleck, White, etc 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify Specify: White 3 XWidowed 4 Divorced 16a. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) College (1-4or 5+) 12th Operator Telephone Co. 18 Mother's Name (First Middle Meiden Sumame) 17. Father'a Name (First, Middle, Last) Lawrence Lewis Pauline McCrobie 19b. Meiling Addresa (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant'a Name/Relationship (Type, Print) Teresa Connor/Daughter 7825 Chestnut Grove Rd., Frederick, Md. 21701 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ₺ Burlai 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/20/99 Oakland, Maryland Taylor Sines Cemetery 21. Signature of Funerel Service License 22. Name and Address of Fecility Stewart Funeral Home 23a. Part1. Enter tha disease, of complications that caused the death. Do not entar the mode of dying, such as cerdiac or respiratory errest, shock, or heer failure. List only one ceuse on each line. Approximate Interval Between Onset end Death Immediate Ceuse (Fine) disease or condition resulting in death) 23b. Did tobacco usa contribute to the cause of death? 14 108 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

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Division of Vital Records,

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7 is marked other than "natural", or frams 23a or 28a-f show trsumstic event, the Medical Examiner must be notified at

al Hygiene.

permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy, important: if flem 27 is marked othe any injury or other traumatic event, pages.

with the Maryland

Maryland 21215-0020

Baltimore,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events that initieted events resulting in daeth) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24b. Ware eutopsy findings avaitable prior to complation of cause of deeth? 24a. Was an autopsy †□Yes 2□ No 1 Yes 2 TNo

examiner?	10 at 10 at	to medical
Manner of	5. □ Dandier	

1 Department 2□ ER/Outpetient 3□ DOA 28a. Date of Injury (Month, Day) 28b. Time of

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 DOther (Specify) 28d. Describe how injury occurred

investigation 2 Accident € ☐ Could not be determined. 3 Suicide 4 Homicide

1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Steta)

29a. Certifier (Check only

1 Certifying Physician: To the best of my knowledgs, dasth occurred et the time, dete end place, and dus to tha ceuse(s) end manner as stated. 2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred et the time, data end place, end due to the cause(s)

29b/Signature and title of certifie 29c. License number

29d. Date signed (Month, Dey, Year) ,1999 **FEBRUARY**

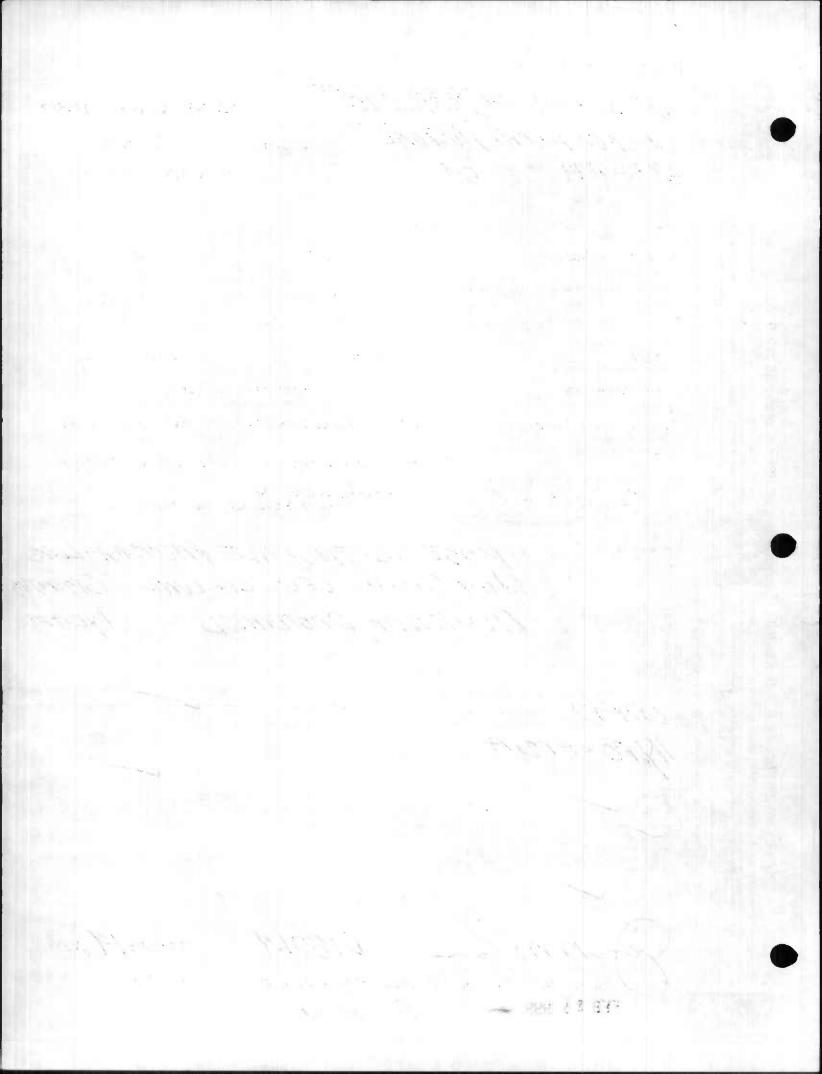
30. Nama and addrass of person who complated causa of daeth (Item 23e) (Type, Print)

Raver MD, 600 Memorial Ave. Suite 400, Cumberland, Md. 21502 31. Dall 1

Registrar

32. Registrar's Signature



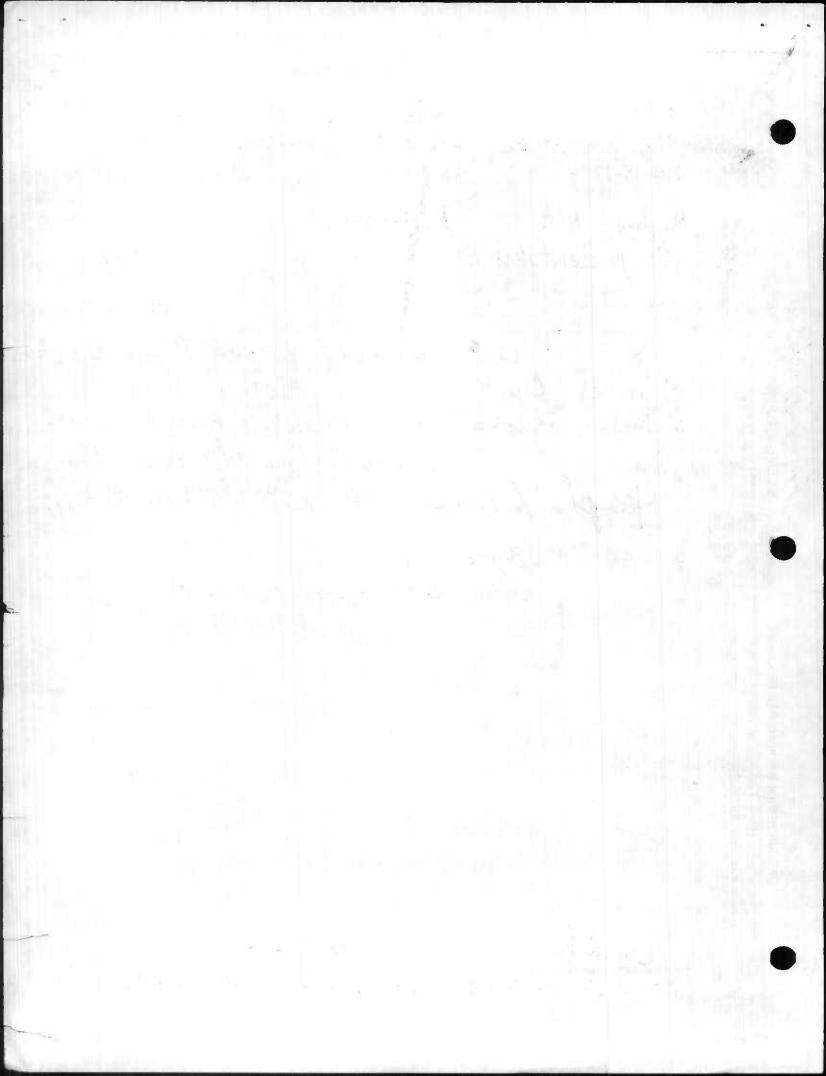


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Physician 15 | 999 4c. County of Death 1419 /Medical Location of Death 4b. City, Town, or 4a Facility Name (If not institution, give street end number) Examiner 5. Sociel Security Number MOI If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Dete of Birth (Month, Day) 9. Birthplaca (Stete or Foreign 6. Sex **Funeral** 1□M 2XF Months Days 129 Yrs. Director Usual Residence of Decedent with the Meryland 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 93 2 21 101 Funerai deeth Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -12. American Indien. 11. Marital Status Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours efter 1 ☐ Yes 2 ☑ No If Yas, Give Yeer or Detas: 1 Never Married 2 Married 1 Yes 20 No Specify. African þ 3 Widowed 4 □ Divorced American Completed 15. Decedant's Education (Specify only highest greda completed) 16e. Decadant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/industry Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than Elemantany/Secondary (0-12) College (1-4or 5+) 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be To X01 (Son 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Pnint) Mel 2/6 0, Baltimore, 20b. Piece of Disposition (Neme of / cametery, crametory or other ple Deta 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Buriai 2 □ Cremation 3 Removal from Stale 19 0 any injury 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Fecil seph 5 era un 0 Ave. W. North Enter the distance, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory arrest, or heart failure. List only one cause on each line. 2 Approximate Interval Between Onset end Death **Physician** Immadiata Causa (Final disease or condition resulting in death) /Medical **Examiner** Dua to (or es a consaquence of); end-stage Physician/Medical Examiner the ettending physician end hed for use as the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es a consequenca of) Box 68760 thet initieted events resulting In death) Lest Due to (or es e consequenca of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. signed by the 1 Yes 2 No 3 Probably 4 Ultriknown by cete has been significant page 2 should b 24b. Were autopsy tindings eveileble prior to 24e. Wes en eutopsy performed? Completed completion of cause of death? certificete has 2 DN 1 Yes Physician: director, 25. Was casa raterred to madical examiner? Be 26. Place of Death (Check only ona) Hospitel: Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 0 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this To the Emeral Director: After this 28e. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Tima ot 28c. Injury at Work? Certification: or Attending 1 Maturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be datarmined 3 Suicide 28a. Placa of Injury - At home, ferm, street, factory, offica building, atc. (Spacify) 28t. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and dua to tha ceusa(s) end manner as stated. 29a. Certifie edica 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and manner stated (Check only # 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific

State Registrar 30 Name and address of person who completed cause of cleath (Item 23a) (Type, Brint)

32. Registrar's Signetura

31. Dete tiled (Month, Day, Year)
MAR 1 8 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Daath 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) **Physician** 13 1999 03:20am March anc he /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number, **Examiner** Sinai Hospital of Baltimore Baltimore City If Undar 1 Yaar If Undar 24 Hrs. 9. Birthplaca (Stata or Foraign Country) 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days Hours 10 M 20 F / Yrs. 2/3-26-75/7 Usual Rasidence of Dacedent **Director** maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits with the Maryler 1 Yas 2 No Directo ore Cryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7 is marked other than "natural", or items 23s or traumetic avent, the Modical Examinor must be r 45 A 14. Race - American Indian, 3501FG Funeral 2120 death 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No 11. Marital Status Black, White, atc. 72 hours efter 1 Nevar Married 2 Married 1 Yas 2 No Maryland 21215-0020 If Yas, Giva Yaar or Datas: Specify þ 3 Widowad 4 Divorced 3/00 Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elamantary/Secondary (0-12) Collega (1-4or 5+) iduc at 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middla, Maidan Sumama) Be 2 should be fand Mental It Walter Baker 2 Comonds TRandallstownMD121133 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Pages 1 and 2 s ment of Health an sh 4320 inc onicsa 20b. Place of Disposition (Nama of cematary, cramatory or other place) Baltimore, 20a. Mathod of Disposition march 8 18,1999 8 Dependent of Important: If it any Injury or c 1 Burial 2 Cramation 3 Ramoval from Stata dow Ridge
22. Name and Address of Facility Doug 1455 4 Donation 5 Other (Specify) Kridge 21. Signatura of Funaral Sarvica Licansee 701 me (ulloh Street, Baltimore, MO, I-uneral ervica llor 23a. P. 11. Enter the dilease, or amplications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximata Intarval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) Subdural Hematoma 2 weeks Examiner Dua to (or as a consequence of): Examiner that the death certificate be executed physician and the burial-transit Sequantially list conditions, if any, laading to immadiate causa. Enter Undarlying Causa (Diseasa or Injury that initieted avents rasulting in daeth) Last Dua to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical Dua to (or as a consaquanca of) 80 esn signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Alzheimers Dementia þ 24b. Wara autopsy findings available prior to complation of causa of deeth? Completed 24a. Was an autopsy Non-Insulin Dependent Diabetes page 2 hes 2 No 1 ☐ Yas 2 No certificate director 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only one) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 1 Inpatiant 10 2 ER/Outpatient 3 DOA After this funeral 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Dascribe how injury occurred 28h Time of 28c. Injury at Work? Certification: 5 Panding invastigation 1 Natural after death. 1 ☐ Yas 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, State) filled in by 4 Hoitrieide 24 hours a Hospital 29a. Certifian 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and dua to the cause(s) end manner es stated. Medical completely (Check only one) 2 Medical Examiner: On the besis of axamination and/or invastigation, in my opinion, death occurred et the time, dete and place, end due to the cause(s) and mannar stated. To the To the To the 29b. Signature and titla of certifies 29c. Licansa number 29d. Data signed (Month, Day, Year)

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Blanche

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Strint

State Registrar Drew J. White, MD
31. Data filed (Month, Day, Yaar)

MAR 18 1999

Sinai Hospital

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

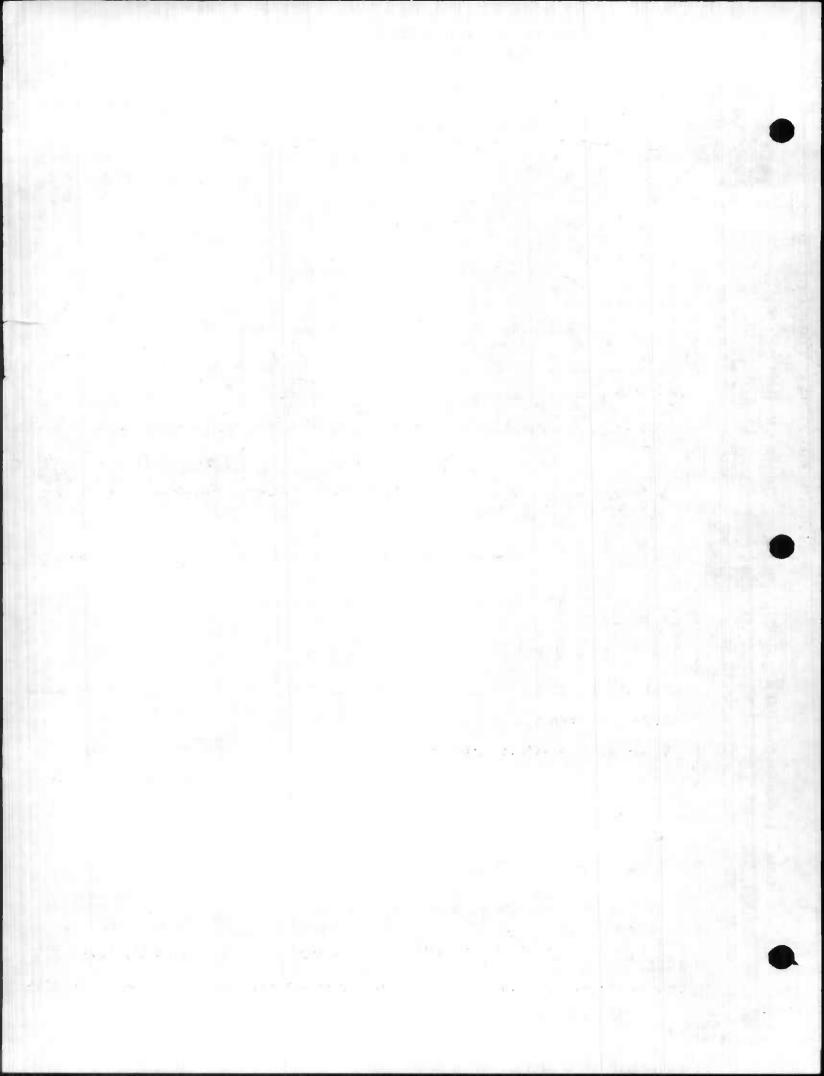
2401 West Belvedere Ave. Baltimore, MD 21215

RES 000

March 13, 1999

32. Registrar's Signatura B. Spark

MD



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Nama (First Middle Last) Dev **Physician** 1999 10:49 pm Patient Known Asi Beasley, Janni 15 dean March annie /Medical 4e Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinal Hospital Baltimore If Undar 24 Hrs. If Undar 1 Year 6. Sax 8. Date of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 1□M 20 F Months Days Hours Min 45 Yrs. 215-60-1119 **Director** Maryland Usual Rasidence of Decedent death with the Manyland 10e. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23e or 28e-f show traumatic avent, the Medical Examinar must be notified at 1 Yas 2 No Directo 10e. Street and Number mor 10g. CitIzan of What Country? 10f. Zip Coda US Funeral Hvenue . Was Decadant Ever in U,S. Armed Forcas? Was Dacedant of Hispenic Origin? (Specify Yes or No-ff Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indien, Black, Whita, atc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yas, Giva Yaar or Datas: filed within 72 hours after 1 ☐ Navar Marriad 2 ☐ Married 1□ Yas 2⊡No Specify: Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast greda complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry and Mental Hygiena. Is marked other than Elamantary/Secondary (0-12) Collega (1-4or 5+) Machinist 1 chans 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be P Beasley (Teaca C 19b. Malling Addrass (Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) 19a. Informant's Nama/Ralationship (Typa, P(int) permit. Pages 1 and 2: Depertment of Haalth a Important: If item 27 Is any Injury or other tracence. 20b. Place of Disposition (Nama of carnatary, cramatory or other place) Jeasley-mother 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funeral Sarvice Lips 22. Name and Addrass of Facility Douglass unera 1701 me Culloh Street, 13 as arthor 23a. Part1. Enter the disaesa, or complicetions thet caused the daeth. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on each lina. Approximata Onsat and Daath **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical Lung Cancer Examiner Due to (or as a consequence of): Physician/Medical Examiner ettanding physician and for usa as the bunel-transit The law requires that the death certificate be assecuted Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that Initiated avants Dua to (or as e consequance of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequanca of): rasulting in daath) Last signed by the e Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings availabla prior to complation of causa of daath? been signature 24a. Was an autopsy performed? Completed certificate has b lirector, paga 2 sl 1 ☐ Yas 2 No To the Hospital or Attending Physician: 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only ona) Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 Yas 2 No 1 Copatiant 2 ☐ ER/Outpatiant 3 ☐ DOA After this funeral 27. Mannar of Daath 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury at Work? Certification: 1 Natural 5 Panding Invastigation 1 Yas 2 No within 24 hours efter deeth To the Funerel Diractor:, completely tilled in by the 6 Could not be datarminad 3 ☐ Suicida 28f. Location (Street and Number or Rurel Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 ☐ Homicida To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2 Madicat Examiner: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) end manner stated. 29a. Cartifiar edicai 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licansa number March 18, 1999 P09292 30. Nama and addrass of person with complated causa of death (Itam 23a) (Type, Print)

Baltimore MD 21215

State Registrar Chu

2401

W Belvedere

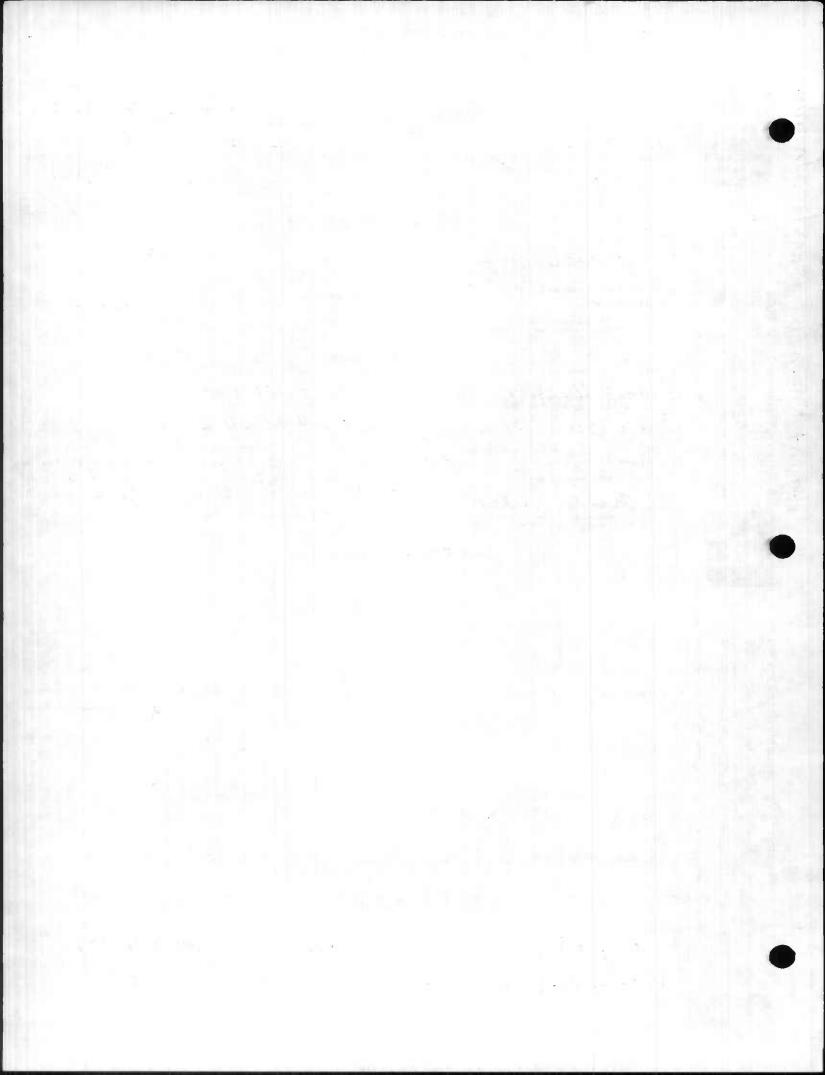
32, Ragistrer's Signatura

Avenue

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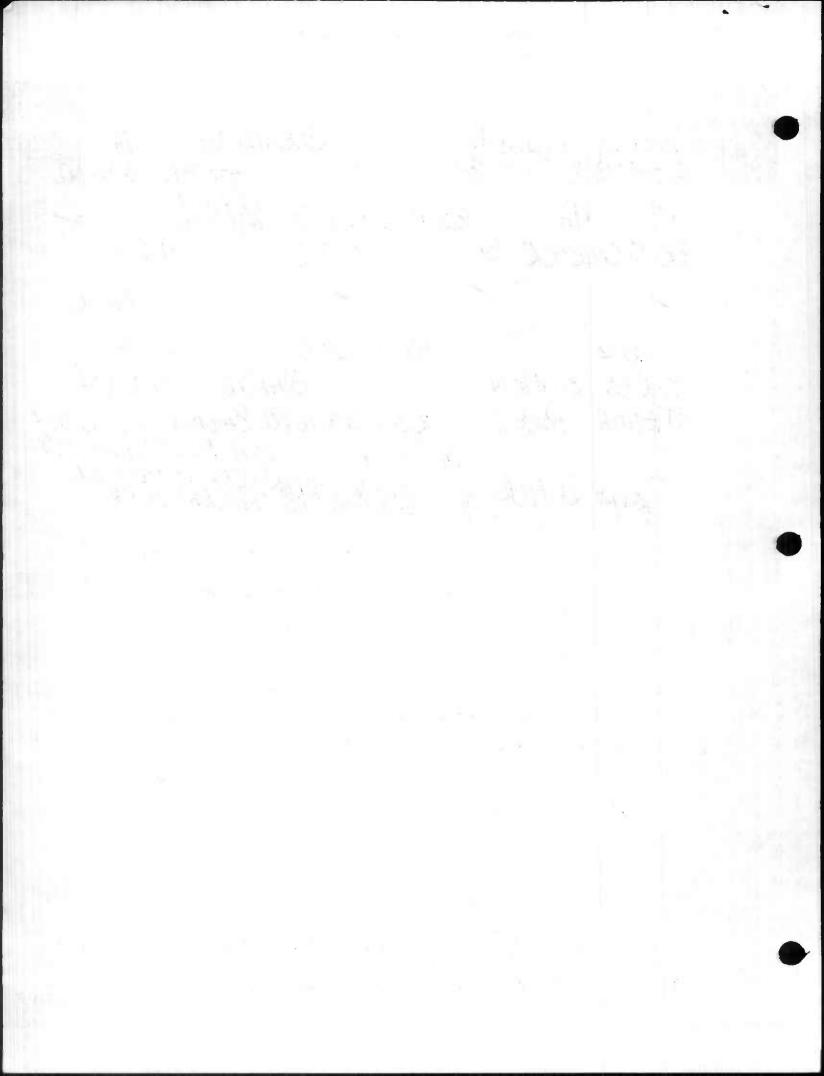
31. Data filed (Month, Day, Yaar)

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Q Q

		Certificate of Death Reg. No.
Physi	ician	1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death
	dical	GENEUIEUE BOOKER MARCH 15 - (999 6:51 P.: 42-Febility Name (If not institution) dive street and number) ACCITY, Town, or Location of Death 4c. County of Death
Exam	iiriei	MERCY HOSPITAT BAIGMOREMY NA
Funera Directo		5. Social-Security Number 6. Sex 1 M 2 F 7. Ase (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 1 Days Hours Min. 9 Birthplace (State of Foreign Usuel Residence of Decedent).
e Meryland 8a-f show	Funeral Director	10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City Town or Location
020 urs s		10e. Street and Number St. 10l. Zip Code 10g. Citizan of What Spuntry?
		3 Wildowed 4 □ Divorcad If Yes, Give Yeer or Dates: 1 □ Yes 2 □ No Specify: Speci
Aaryland 21215-0 2 should be filed within 72 he and Mental Hygiene. Is marked other than "natur sumatic avent, the Medical	Completed	15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife, DO NOT use retired)
	To Be Co	18. Mothel's Name (First, Middle, Last)
		19a, Informent's Nemer Gelation Prip (Pype, Print) 19b. Mailing, Addressy's five and Number or Sural Poyte Number, City or Town, State Zip Code) 20e. Mathod of Disposition 20e. Mathod of Disposition 20e. Place of Disposition (Name of Date 20e. Security City or Town State)
Baltimore, Nemit. Pages 1 and Depertment of Heelth Important: If Item 27 any Injury or other tr	4	1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) 21. Signature of Funerel Service Licenser
Balt permit. Depertu	Sales Sa Sales Sales Sales Sales Sales Sales Sales Sales Sales Sa Sales Sa Sa Sales Sa Sa Sa Sa Sa Sa Sa Sa Sa Sa Sa Sa Sa	oseph D. JOCHO A. SATINGENTAL FUNERAL HOME
Physicia: /Medica		23a. Pent / Enter the disease, or complications thet vaused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Interval Between Onset and Deeth Immediate Ceuse (Final disease or condition LEFT LOWEN LOBE PNEUMONIA
Examine		disease or condition resulting in deeth) Due to (or es e consequence of):
rted I	Examiner	b. SEUERE DEBILITATION
58760, icete be executed physician and s the buriel-transit		Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or es e consequence of): ADVANCED ALZHE (MEN'S D(SERSE)) Due to (or es e consequence of):
x 68760, entificete be ex ding physician t	Medical	thet initialed events resulting in deeth) Lest Due to (or es e consequence of): d.
Box death cert attendin d for use	Physician/N	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death?
b, P.O. Box 6: s that the death certificated by the attending p	by Phys	RENAL INSUFFICIENCY 1 Yes 20 No 3 Probably 4 Unknown
vision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed rideath. ector: After this certificate hes been signed by the attending physician and by the funeral director, page 2 should be detached for use as the buriel-transit	Completed b	METABOLIC ACIDOSIS 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of deeth?
Vital Rec sicien: The law certificate hes b lirector, pege 2 s		1 Yes 2 No 1 Yes 2 No
Vita sician s certifi	To Be	25. Wes case referred to medical exeminer? 1 Yes
ing Phys wher this	On: T	27. Manner of Death 1
Division of Vital Records, To the Hospital or Attending Physician: The law requires th within 24 hours efter death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be or	Certification:	2 Accident 3 Suicide 4 Homlcide Name
e Hospita 24 hours Funeral	edicai C	29a. Certifier (Check only one) Check only one)
To the To the comp	Me	29b. Signature end title of certifier 29d. Date signed (Month, Dey, Year)
n 4		Joseph D. Notorangelo M.D. DO 7316 MANCH 15-1999
a bas		30. Neme and address of person who completed cause of death (Item & 3a) (Type, Print) JOSEPN D. NOTA RANGELO M. D. 301 ST. PAUL PLACE BALTIMONE 31. Dete filed (Month, Day, Year) 32. Registrer's Signature 2120
S	tate	31. Dete filed (Month, Day, Year) MAD 1 8 1999 32. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death

3. Tima of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Yee BARRINGER **Physician** RUSSELL 5:17 P.M MARCH 1999 15 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street and number) **Examiner** BALTIMORE HARBOR HOSPITAL CENTER If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Year Months Deys 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 6 Sex **Funeral** 1**X**M 2□ F Months 214 26 8269 Sept. 11,1930 Director Pennsylvania Usual Residence of Decedent tha Maryland 10c City Town or Location 10d. inside City Limits 10a State 10b County "natural", or items 23a or 28a-f show 1X Yes 2 No Maryland N/A Baltimore Director 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 3824 W. Bay Avenue 21225 U.S. Pages 1 and 2 should be filed within 72 hours aftar death vant of Haaith and Mental Hygiena. nt: If Item 27 is marked other then "natural", or Items 23s Funeral 12. Was Deceden! Ever in U,S. Armed Forces? 1 ☐ Yes 2 20 No if Yes, Give Year or Dates: 14. Rece - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Merital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) marked other than Truck Driver Local 557 8th 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Be Virginia Welsh George Barringer 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Coda) 19a. informenl's Name/Ralationship (Type, Print) Mabel Barringer / wife 3824 W. Bay Avenue Baltimore, Maryland 21225 item 27 20b. Place of Disposition (Neme of cemetery, crametory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State = 0 Glen Haven Memorial Park 3/19/99 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signatura of Funaral Sarvice Licenses Gonce Funeral Home P.A. nplications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, Baltimore, Md. 21225 erom 23a Pari 1. Enter the diseese or shock, or heart tailure. List complications that caused the only one cause on each lina. Approximata Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final e. ACUTE CARDIO PULMONARY ARREST
Due to (or as a consequence of): TEN MINUTES disease or condition resulting in death) Examiner Examiner VENTRICULAR TACHYCARDIA

Due to (or as e consequenca of): TWENTY MINUTES physician and the bunal-transit law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Causa (Diseasa or Injury thet Initieled events resulting in death) Last TWO Records, P.O. Box 68760, DNE () MONIA

Due to (or es e consequence of): WEE KS **Physiclan/Medical** O NON SMALL CELL LUNG CANCER WITH METASTASIS 122 Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part i. 23b. Did tobacco use contributa to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown CHRONIC OBSTRUCTIVE LUNG DISCASE þ 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Was en eutopsy Be Completed CEREBROVASCULAR ACCIDENT certificate has blirector, paga 2 s CORONARY ARTERY DISEASE

25. Was case referred to medical examiner? 1 Yes 2 No 2 100 1 ☐ Yes Division of Vital 26. Placa of Daath (Check only one) Hospital: 1 Impatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 2 No P 28d. Describe how Injury occurred 27. Manner of Death 28b. Tima of

Attending Physician: ospital or Attend hours aftar death uneral Director: / the Funeral Director filled in by the Medicai To the Hosp within 24 ho To the Fune completaly fi

28e. Data of Injury (Month, Dey Year) 28c. Injury et Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, streel, factory, offica building, atc. (Specify) 4 D Homicide 1 Certifying Physician: To the best of my knowledga, daath occurred at the time, date and place, end due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and mannar statad. 29a. Cartifier (Check only one)

29b. Signature and title of certifiar

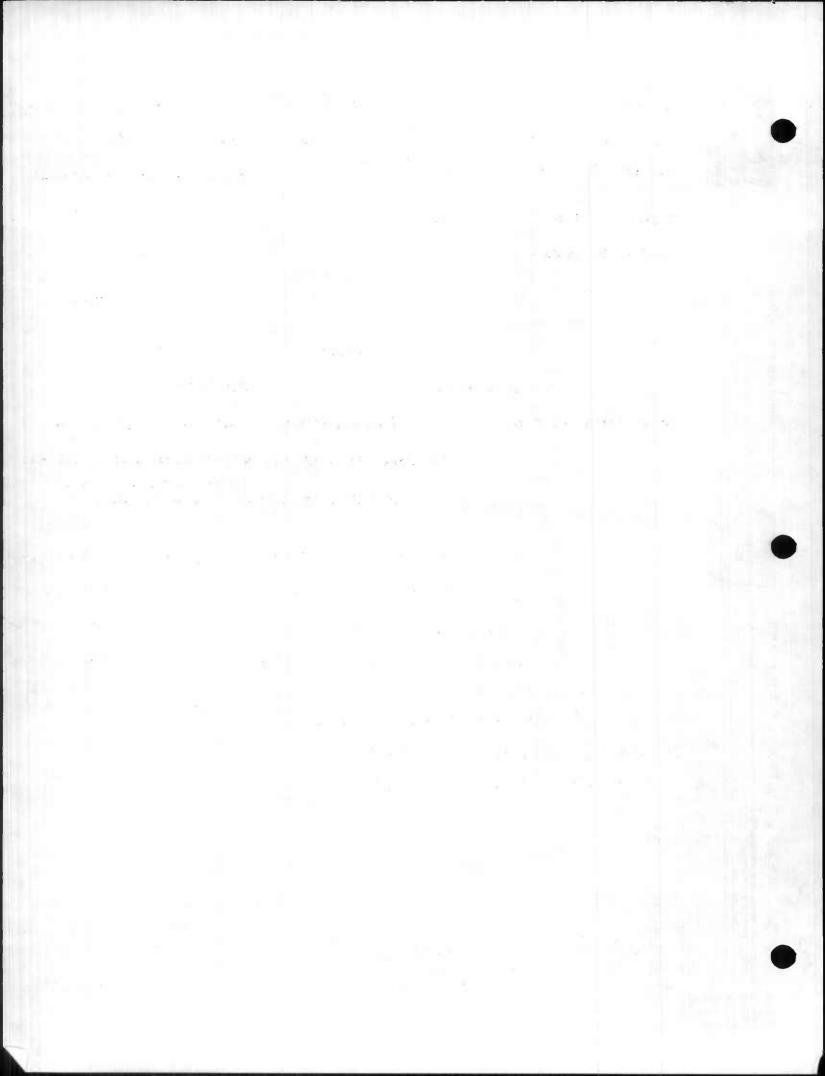
29c. License number HOUSE STAFF 11031 29d. Date signed (Month, Day, Year) MARCH, 15, 1999

30. Name end address of person who completed cause of daath (Itam 23a) (Type, Print)

3001 S. HAUSVER ST. HOSPITAL CENTER 5. MEROGI HARBOR

State Registrar

32. Registrar's Signature 31. Dete filed (Month, Day, Year) MAR 1 8 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** Month Thomas Blake. /Medical 6:25 am 4a. Facility Nama (If not institution, giva street and number) **Examiner** Stella Maris Hospice Timonium Baltimore If Undar 1 Yaar | If Undar 24 Hrs. 8 5. Social Sacurity Number 216-12-0758 7. Aga (In yrs. last birthday) 79 Yrs. Birthplaca (Stata or Foreign Country)
 VA **Funeral** Days Months Hours 1 M 2 □ F Director Usual Rasidanca of Decedant the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f abov traumatic event, the Medical Examiner must be notified at MD Baltimore Raspburg 1 Yas 2 No Director 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? With 5202 McCormick Ave. 21206 USA Funeral 12. Was Decedant Evar In U,S. Armed Forcas? 14. Race - Amarican Indian, Biack, Whita, atc. Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 17 Yas 2 No If Yes, Giva WW II Yaar or Datas: 1 Navar Married 2 Married Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: White PV 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry al Hygiene. Elamantary/Secondary (0-12) Collega (1-4or 5+) Tin Mill Worker Bethlehem Steel permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If Item 27 is marked other
any injury or other traumatic avant 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Robert Blake Laura Thomas 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Ruth S. Blake / wife 5202 McCormick Ave. Baltimore, MD Baltimore, 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ∑Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Spacify) Parkwood Cemetery 3-18-99 Parkville, MD 22. Name and Addrass of Facility CVach/Rosedale Funeral Home 21. Signature of Funaral Sarvice Licens 1211 Chesaco Ave. Rosedale. MD 21237 MUS-E 23a. Part1. Enter tha disaasa, or complications that caused the shock, or heart failura. List only one cause on each line h. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, Approximata Intarval Batween Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or conditior rasulting in daath) LUNG CANCER Examiner Dua to (or as a consequanca of): Examiner Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): Physician/Medicai 2 Dua to (or as a consaquance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobecco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4X Unknown Completed by 24b. Wara autopsy findings available prior to complation of causa of daeth? 24a. Was an eutopsy performad? has 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital Be 25. Was casa rafarrad to medical 26. Placa of Daath (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Nothar (Specify) HOSPICE 1 Yas 2 XNo Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? After 1 XNatural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant or Attend after death Director: 6 Could not ba 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury · At homa, farm, straat, factory, offica building, atc. (Specify) 4 Homicida An 24 hou. the Funeral Dir 1 Certifying Phyaician: To tha best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, data and place, and due to the causa(s) and mannar stated. 29a. Cartifiar (Check only one) To the F within 2 To the F 29b. Signatura and titla of cartifia 29c. Licansa number 29d. Data signed (Month, Day, Year)

State Registrar

MAR 1 8 1999

DR. TARIQ MAHMOOD

31. Data filad (Month, Day, Year)

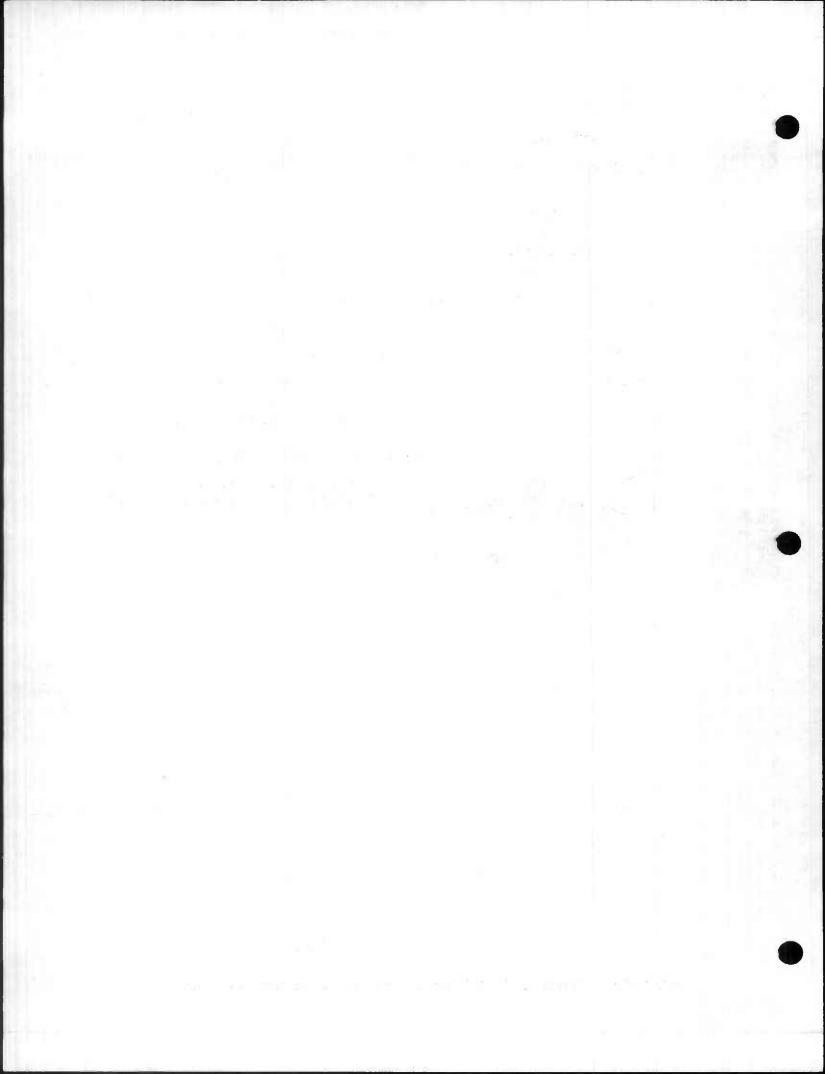
32. Registrar's Signature

30. Nama and addrass of parson who completed cause of death (item 23a) (Type, Print)

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Yaar **Physician** Damon Lane Barnhart 232 march 14 1999 /Medical 4c. County of Death 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death Examiner Hagerstown Washington Washington County Hospital If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Yaar) March 23, 1921 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foraign **Funeral** Months Days Hours 1₽M 2□ F Maryland 219-01-1486 Director Usual Rasidence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rail, or items 23s or 28s-f show Examiner next be notified at Maryland Washington Hagerstown 1 ☐ Yas 21 No Director 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1216 North Prospect Street 21740 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Black White atc 72 hours after 1 ∑Yes 2 ☐ No If Yes, Give Year or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 natural, or 1 Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4-☑ Divorced 16a. Decedent'a Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry the Medical permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any Injury or other traumatic avant, the Magnitos others. Elementery/Secondary (0-12) College (1-4or 5+) unknown unknown 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be Myrtle Arabella Haller Nimrod O. Barnhart 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry Barnhart/daughter unknown 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donetion_5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade, Stare and Address of Facility and, 655 W. Baltimore Street Director Baltimore, Maryland 21201 23a. Pair 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Intarval Between Onset and Daath **Physician** Immediata Causa (Finel disaasa or condition rasulting in death) /Medical Examiner Diolonged Examiner Cardler Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last physician s the burial Encephalopathy Box 68760, Anoxic Physician/Medical Due to (or as a cons Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yee 2 No 3 Probably 4 Unknown 2 paga 2 should Completed 24a. Was an autopsy performed? 24b. Wara autopsy tindings available prior to complation of cause of death? 22 No 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physician: funaral director, 25. Waa casa rafarred to medical axaminar? Be 26. Place of Death (Check only ona) 1 Yes 2 No Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Certification: To Ampatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28b. Time of Injury 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 5 Pending invastigation 1 Natural 1 Yes 2 No 24 hours after death. 2 Accident tha Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) completely filled in by 4 Homicide Hospital 1 Cortifying Physician: To the best of my knowledge, death occurred et the tima, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 To the To the 29b. Signature and title of certified 29c. License number 29d. Data signed (Month, Day, Year)

State Registrar

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DHMH 16 Rev 6/95

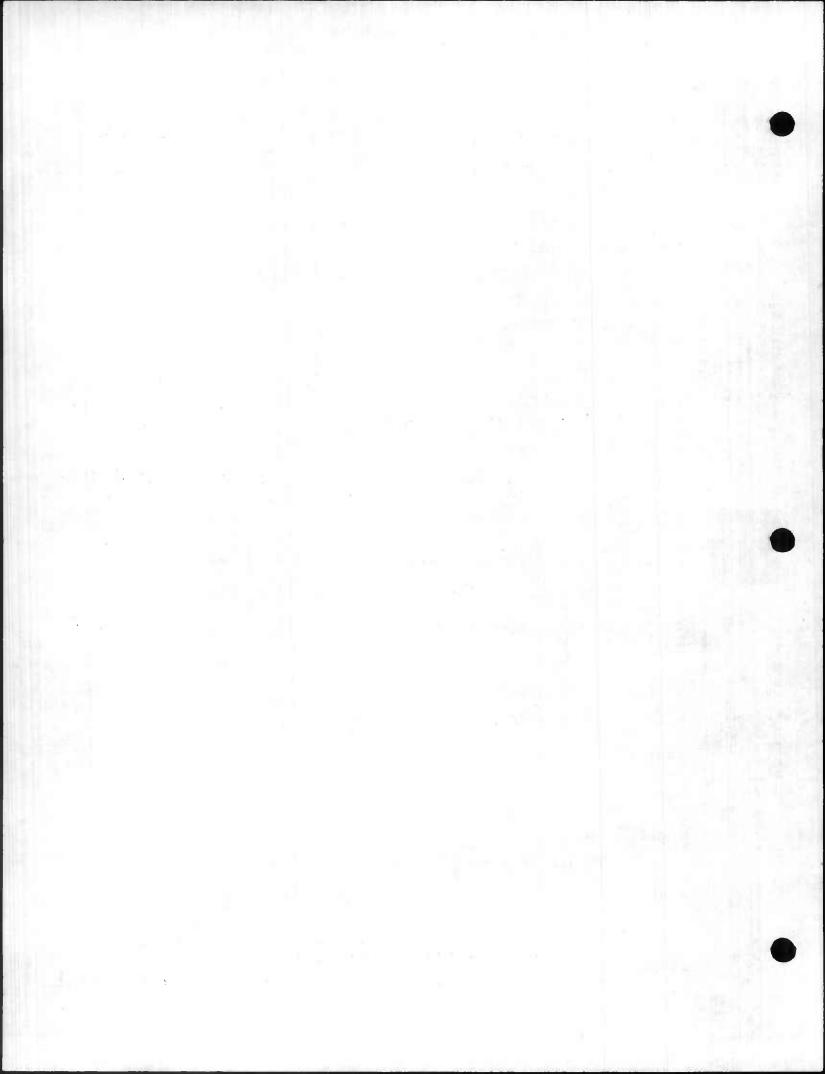
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/32. Registrar's Signature



Funeral

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27, 28A-F PER MED Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** FEBRUARY 1, 1999 Baby Boy Berduo 1620 PM · /Medical 4b. City. Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not Institution, give street end number) Examiner LOT 15 WALKERS TRAILER PARK MARYDEL CAROLINE If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Year) Hours 1 M 2 □ F Yrs Feb. 1, 1999 unknown Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. toside City Limits 1 ☐ Yes 2♥ No Maryland Caroline Marydel Director 10f. Zip Code 10g. Citizen ot What Country? 10e. Street and Number Lot 15 Walkers Trailer Park 21649 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1XXes 2□No Specify: Guatemala Specify: Hispanic þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 N/A N/A 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be unknown Hermania Berduo 2 19a. tntormant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Det. Nancy Reynolds (410-479-2515) Caroline County Police Department 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burlai 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Ronald Service Licensee Ronald S. Wade, Director State Anatomy Board, 655 W. Baltimore Street Maxa Baltimore, Maryland 21201 anales 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DROWNING AND ASPHYXIA Due to (or as a consequenca ot): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es a consequence of). 23b. Dtd tobecco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings available prior to 24a. Was an autopsy Completed completion of cause of death? 1 Wes 2 No 1 ☐ Yes 2 ☐ No 25. Was case reterred to medicat examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 □Other (Specify) Yes 2□ No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) Found: 2-1-99 28d. Describe how Injury occurred 27. Manner of Death 28h Time of 28c. Injury at Work? Certification: Found: 1 Naturel 5 Pending 1 ☐ Yes 2 X No investigation 2 Accident INFANT DROWNED AND ASPHYXIATED 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) LOT 15, WALKERS 3 ☐ Sulcide 28e. Ptaca of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homicide FOUND: TRAILER TRAILOR PARK, MARYDEL, MARYLAND 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier **OCME** FEBRUARY 2, 1999 30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

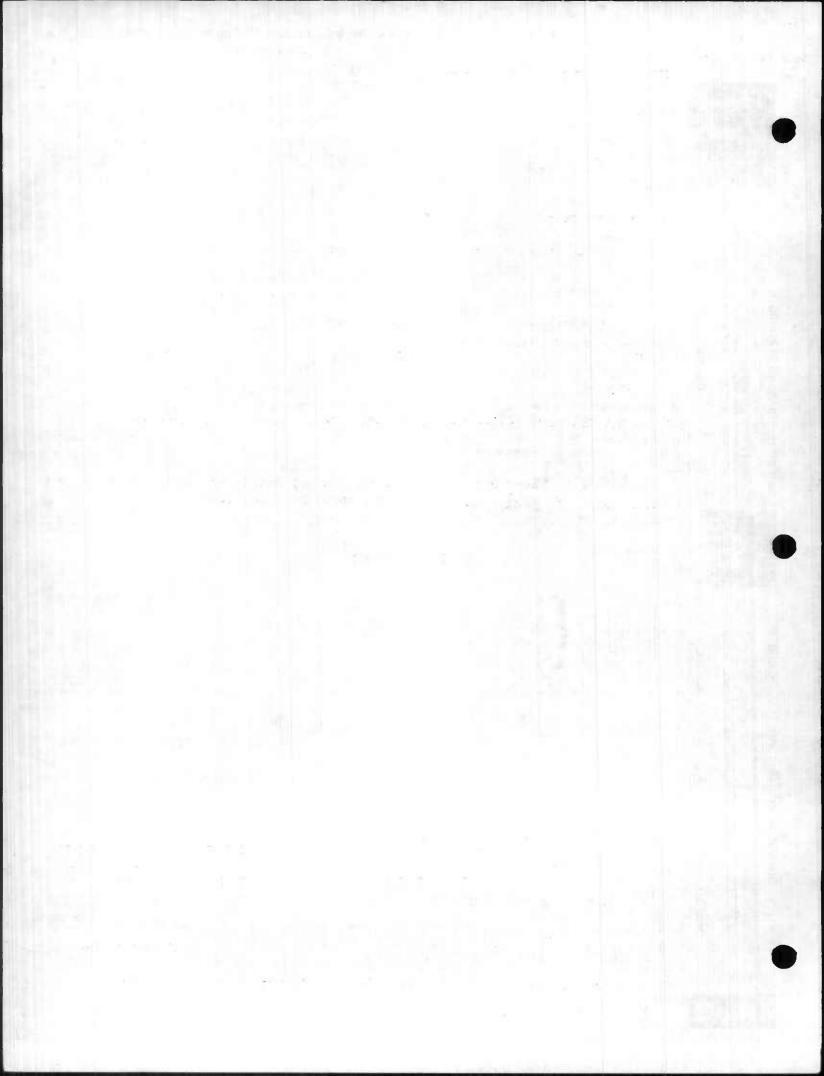
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31. Date tiled (Month, Day, Yeer) MAR 18 1999

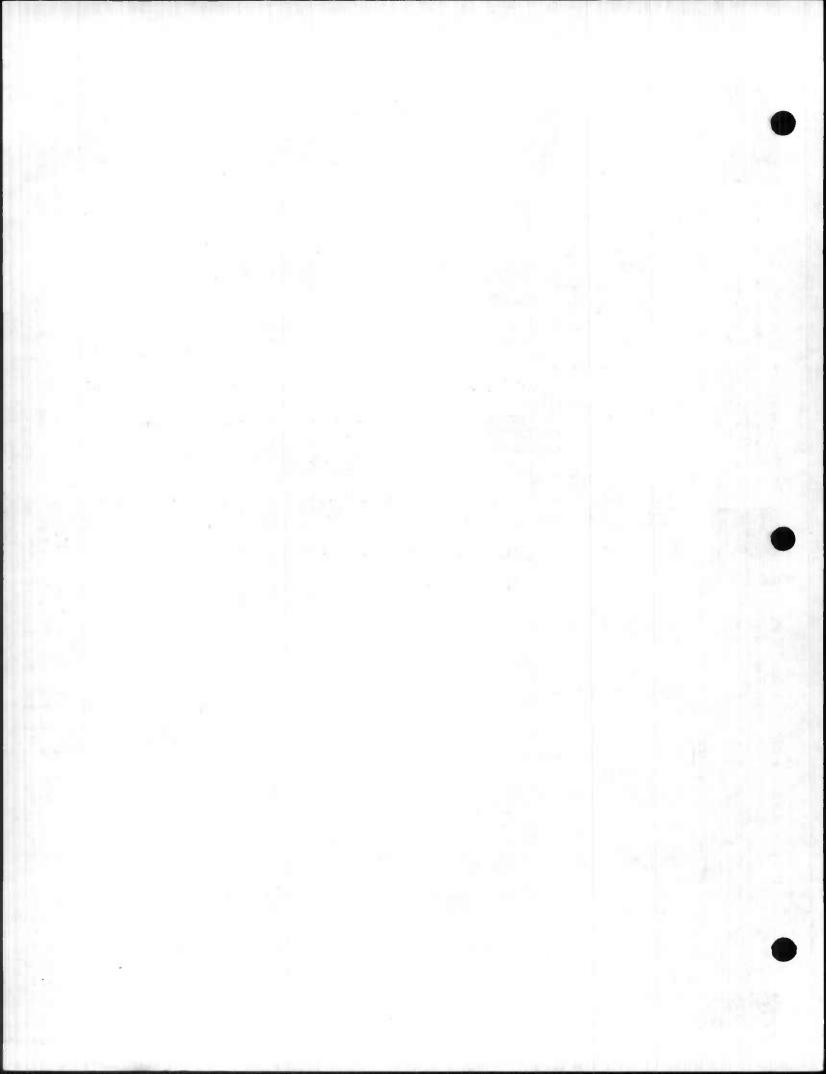
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A. Kolow (W) 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Deta of Death 3. Tima of Death Month **Physician** COYNE FRANK 11:12Am 99 march /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bal Harbor Hospita TIMOre N/A If Under 24 Hrs. If Under 1 Year 5. Social Security Number 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Days Months Hours 213 10 9216 M 2 F 87 Nov. 4, 1911 Director Maryland Usuel Residence of Decedant the Manyland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Wedges Examiner must be notified at Maryland ¥ Yas 2 No N/A Baltimore Director 10a. Street and Number 10f, Zip Code 10g. Citizen of What Country? 4151 Doris Avenue 21225 U.S. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva 14. Race - American Indien, 11 Meritel Stetus Black, Whita, atc. 1 ☐ Nevar Married 2 N Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 Widowed 4 Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry ifiled within 7 Hygiene. Elamentery/Secondery (0-12) Collega (1-4or 5+) permit. Pages 1 and 2 should be filled wi Department of Health and Mental Hygien Important: If Isan 27 is marked other thy sny Injury or other traumatic aware 8th Firefighter Baltimore City 17. Father's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be (not available) Henry Coyne Katie 19a. tnformant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Lillian Coyne 4151 Doris Avenue Baltimore, Maryland 21225 20b. Piece of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Ramovai from Stata 3/16/99 Baltimore, Maryland St. Stanislaus Cem. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licensae 22. Nama and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. Lintonic one cause on each line. Approximeta Intarval Between Onset and Death **Physician** Obstructive Lung Disease years /Medical Immediate Cause (Final disease or condition rasulting in death) Examiner Dua to (or as a consequence of): Examiner Days Pheu monia physician and s the burial-transit certificate be axecuted Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or injury that initiated evants resulting In death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed peeu has 1 Yes 2 No 1 Yas 2 No Division of Vital Be 25. Was casa referred to medical axaminar? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 TYAS 2 No 1 (Inpatiant 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attanding P. within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 28b. Time of Certification: After 1 Natural 5 Panding 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homlcide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Cartifiei (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifier Shimos 30. Name and address of person who complated ca so of death (Item 23a) (Type, Print) 5. Hanover St. Baltimore 3001 JAMES HORODYSKI 31. Date filed (Month, Dey, Year) 32. Registrar's Signatura State MAR 18 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** 11:40AM Colglazier 13, 1999 March /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COLLEGE MANOR LUTHERVILLE BALTIMORE 5. Social Security Number 7 Age (In vrs lest hirthday) If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1 M 2 D F Hours 220-46-6857 88 MARCH 28,1910 VA Usual Residence of Deceden 10a Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yas 2 No Director BALTIMORE LUTHERVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 WEST SEMINARY AVE. U.S.A. 21093 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 230 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 Yas 2 No Specify: Specify: WHITE à 3℃ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16h Kind of Business/Industry INTERNAL REVENUE Elementary/Secondary (0-12) College (1-4or 5+) AGENT SERVICE 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Father's Nama (First, Middle, Last) Be EZRA DAVIS ANNA GILLETTE 19e. Informant's Name/Ratationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAREN HODGES/NIECE 26290 TYLER CIRCLE COURTLAND, VA 23837 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/28/99 RIVERSIDE CEMETERY COURTLAND, VA 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility
STERLING-ASHTON-SCHWAB FUNERAL HOME, INC. maskmanhal 736 EDMONDSON AVE. CATONSVILLE, MD 21228 23a. Part1. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death My6cardial Interrition Immediata Cause (Finel diseasa or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Due to (or as a consequence of): Part fl. Other significant conditions contributing to death but not resulting in the underlying causa given in Part f. 23b. Did tobacco use contribute to the cause of death? Dementia 3 Probably 4 Unknown 1 Yes 2X No ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed No 1 ☐ Yas 2 ☐ No 1 Yes 25. Was casa refarred to medical axaminer? edical Certification: To Be 26. Place of Death (Check only one) 1□ Yas No Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1/2 Netural 2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and mannar as stated.

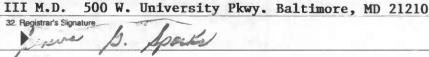
Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, data and place, and dua to the causa(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Mosth, Day, Year) 30. Nama and address of person who combined cause of death (Item 23a) (Type, Print)

State Registrar

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Iredell W. Iglehart,

31. Data filed (Month, Day, Year)



DHMH 16 Rev 6/95

Funeral

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Department of Health and Mental Hyg.
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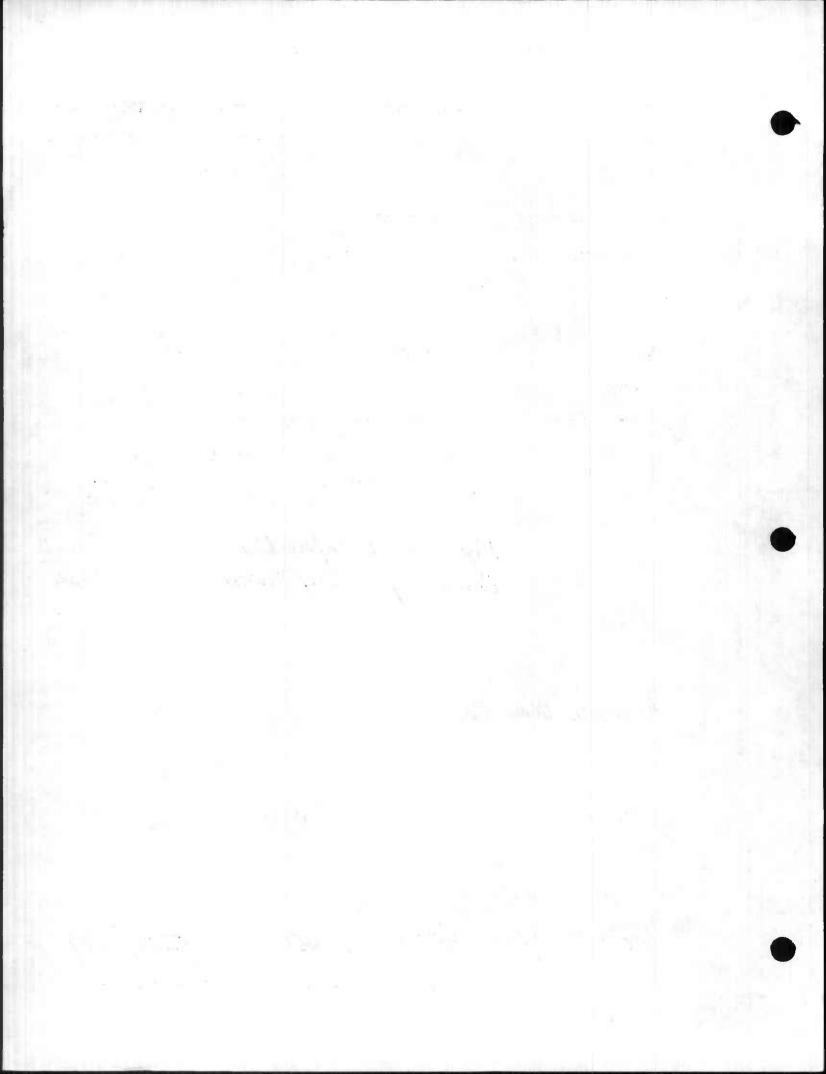
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Physician
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NATHANIEL COTTMAN

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ohysician and the burial-transit The law requires that the death certificate be axecuted ES I use for a datached f sign be should page 2 has certificate Attanding Physician: After this funeral death. after deati filled in by 6 Hospitat 24 hours To the Hosp within 24 hor To the Fune completely fi

Box 68760.

Division of Vital Records, P.O.

4a Facility Name (If not institution, giva street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Baltimore City 606 BRUNE ST. BALTIMORE If Under 1 Yaar If Undar 24 Hrs. Birthpleca (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Deys Hours Min 1₩ 2□ F unknown Yrs. unknown unknown unknown Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore City Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21201 U.S.A. 606 Brune Street 14. Race - American Indian, Black, White, atc. 11. Maritel Stetus unknown 12. Wes Decedent Evar in U,S. Armed Forces? unknown Wes Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Datas: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Father's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) 89 unknown 2 unknown 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) unknown 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donetion 5 € Other (Specify) in state of Priema Service Licensee de State Anatomy Board, 655 W. Baltimore Street Director Baltimore, Maryland 21201 Pert1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting in deeth) Diabetic Ketoacidosis Due to (or es a consequence of): Examiner Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in deeth) Lest Dua to (or as a consequence of) Physician/Medical Due to (or es e consequence of) 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I 3 Probably 4 Unknown 1 Yes 2 No þ 24b. Were eutopsy findings eveilable prior to Completed 24e. Wes an eutopsy performed? completion of causa of death? 1 Yes 2 | No 1 TYAS 2 No 25. Wes case referred to medical exeminer? Be 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 N Rasidence 6 Other (Specify) 1 X Yes 2 □ No To 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Certification: 1 Neturel
2 Accident 5 Pending Investigation 1 Yes 2 No 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stefe) 3 Suicida 28a. Plece of Injury - At homa, farm, streat, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier edicai 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated.

State Registrar (Check only one)

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29c. License number 29d. Dete signed (Month, Dey, Year)

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2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

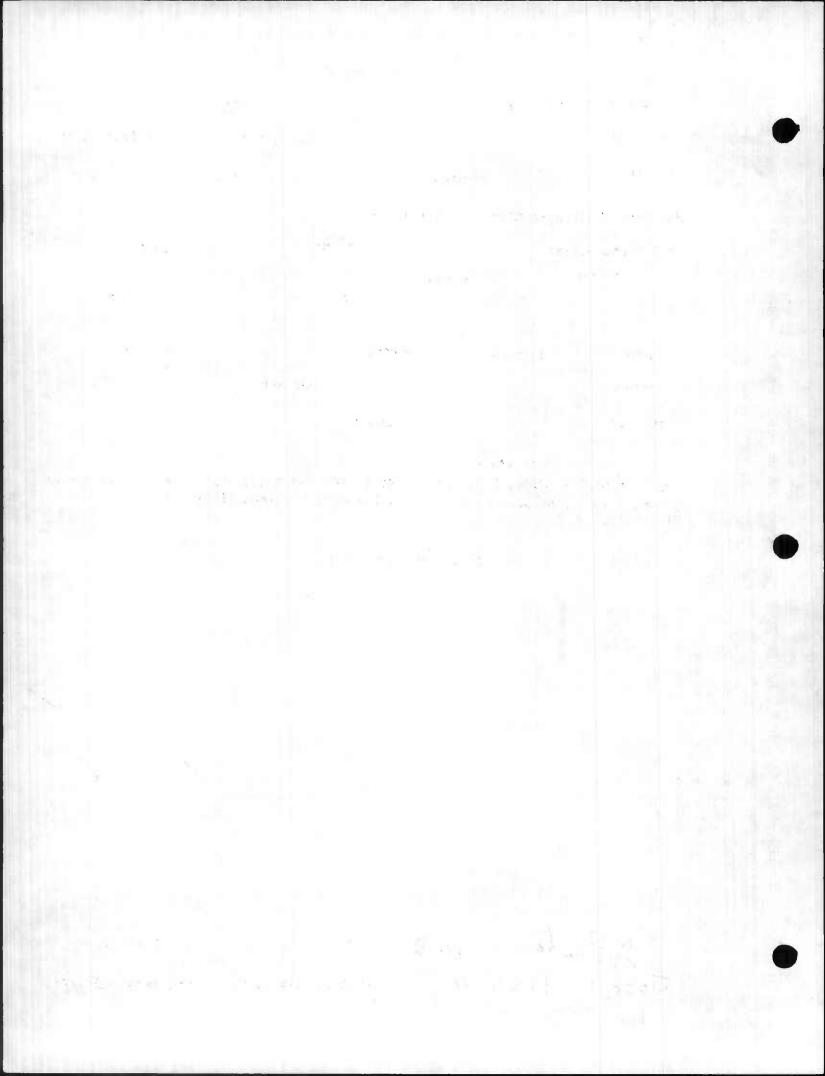
FEBRUARY 12,1999

ess of person who completed cause of death (Item 23e) (Type, Print)

Taner

2. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month **Physician** 9:58 AM DORIS DAIGLE 1999 EBRUARY 28 /Medical 4c. County of Death 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death / Examiner Takoma Park Montgomery Washington Adventist Hospital 8. Date of Birth (Month, Day, Year)
.Tan. 3, 1918 If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) NJ **Funeral** Months Hours 1 ☐ M 2 🗓 F 81 Yrs. 129-05-8752 Morris Plains Director Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahow the Madical Examiner must be notified at Silver Spring, MD TY Yas 2 No Director MD Montgomery 7901 Woodbury Drive 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 20910 USA 7901 Woodbury Drive Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Giva Was Decedent of Hispanic Origin? (Specify Yas or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐No Specify: Specify: à White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Private Industry 12th Legal Secretary other 1 Department of Health and Mental Hyg Important: If Item 27 Is marked other any Injury or other traumatic avent, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Charles Petersen Augusta Petersen 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20910 Romeo J. Daigle/husband 7901 Woodbury Dr. Silver Spring, MD 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3-2-99 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, MD 22. Nama and Addrass of Facility LATNEY'S FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 3831 Georgia Ave., NW Wash., DC 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final Diastolic Dysfunction disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner Exacerabated COPD. Years physician and s the burial-transit that the death certificate be assocuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence ot) Box 68760, Upper GI Bleed Physician/Medical Dua to (or as a consequanca of): attending p 80 Atrial Fibrillation USB P.O. Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 94 signed by t 1 Yes 2 No 3 Probably 4 Unknown Renal Insufficiency þ 24b. Were eutopsy tindings evailable prior to complation of causa of death? 24a. Wes en eutopsy performed?

Division of Vital Records. page 2 or Attending Physician: Affer

Completed Be

1 Yes 2 No 25. Was case reterred to medical 26. Place of Deeth (Check only one) Hospital: 1 Nnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edicai Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Neturel 5 Pending within 24 hours after death.

To the Funeral Director: Al
completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicida 28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier t. Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. within 2. 29c. Licanse number 29d. Data signed (Month, Day, Year) 29b. Signatura and title of certified

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who

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ussuf MI) 32. Registrar's Synature

gompleted cause of death (Item 23a) (Type, Print)

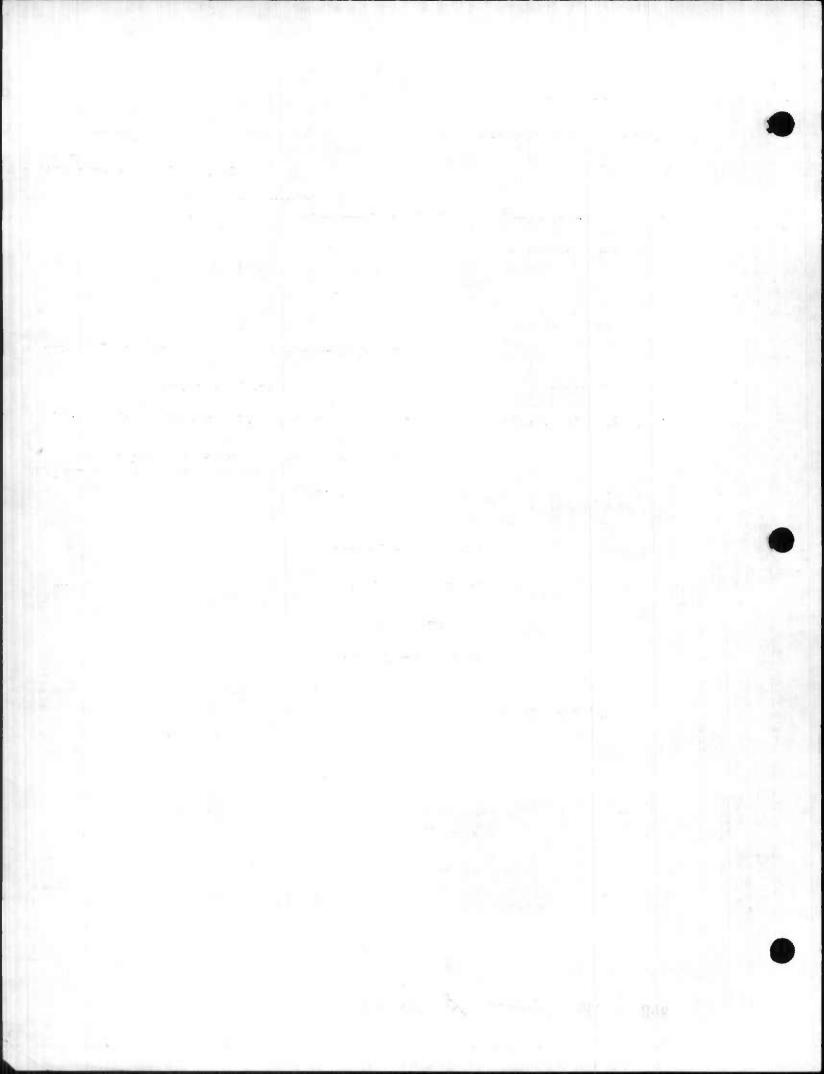
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1 ☐ Yes 2 ☐ No

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Hospital

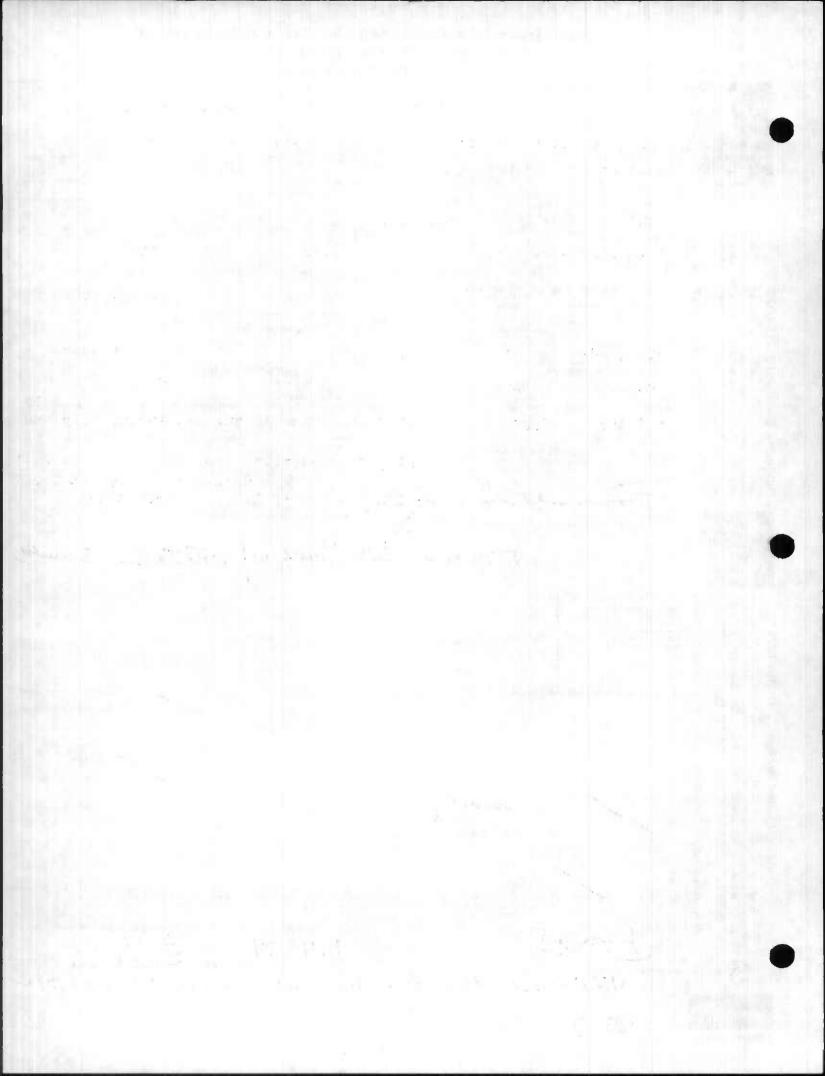
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				Certif	icate of	Death		Reg. No.	UC	624	
nysician-	1. Decedent's Name (First, Middle, Last) Harry Epps						2. Date of De Month	Day	Yeer	3. Time of Death	
al	Harry 4a Facility Name (If not institut	ion, give street and num		52		4b. City, Town, or L	March ocation of Deet	/	99 of Death	12:34pm	
iner	Johns Hop					Baltime	ore	NA			
	5. Social Security Number 228-38-6642		7. Age (in yrs. las 64		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 08-08	th y, Year) 3-34	9. Birthol Count	ace (State or Foreign (Y) A	
	Usual Residence of Decedent 10e. State 10b. Cour	ıtv	10c. City,	Town or Location	on				10	d. Inside City Limits	
Maryland 21215-0020 d 2 should be filed within 72 hours after death with the Maryland d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7.1s marked other than "natural", or items 23a or 28a-1 show traumatic event, the Medical Exam for must be notified at traumatic event, the Medical Exam for must be notified. To Be Completed by Funeral Director	MD	NA		timore						1√ Yes 2□No	
	10e. Street and Number 1618 Clift		Of. Zip Code 212	13		10g. Citizen of W USA	hat Count	ry?			
	11. Merital Status 1 □ Never Merried 2 ☑ Married 3 □ Widowed 4 □ Divorcad 12. Wes Decedent Ever in I Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:			.S. 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuben, Mexican, Puerto Rice 1 ☐ Yes 2 ☐ No Specify:				pecify Yes or No- Rican, etc.) 14. Race - American Indien, Black, White, etc. Specify: Black			
2000	15. Deced	ent's Education nest grade completed)		16a. Decedent's Usual Occupation				16b. Kind of Business/Industry			
	Elementery/Secondery (0-12 10th grade		4or 5+)	(Give kind of work done during most of working life. DO NOT use retired) Fulltime				Auto-Mechanic			
	17. Father's Name (First, Middle	_				18. Mother's Nan Rosa	ne (First, Middle	Maiden Sumeme Grav			
	Luther 19a, Informant's Name/Relatio	Epps		19h Mailine A	ddress /Strant		ral Roude Alumb			Code) 21213	
	Shirley	Epps		1618	Clift	view Av	enue B	altimor	e, 1	Maryland	
	20a. Method of Disposition		20b. Plac	ce of Disposition			Date	20c. Location - 0			
	N Buriel 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other		otate			Bapt.Ch	. Cem.	03-20-	99 I	Burkeville	
	21. Signature of Funeral Service	to Licensee	25	22. Na	ame and Addre		Baltim			and 21202	
	23a. Part1. Enter the disease, shock, or heart feilure. L	or complications that co ist only one cause on es	used the death						1	Approximate Interval Between Onset and Death	
	immediate Cause (Finel disease or condition resulting in death)	. Ino	pulle Due to (or e	c C/	4 y (ce of):	ung w	1 met	astasis	2-	8 weeks	
Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last	c		as a consequen							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.						23b. Did tobacco use contributa to the cause of death?				
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							1 🖸		3 Prot	ore autopsy findings blieble prior to inpletion of cause	
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Completed	25. Was case referred lofned	cal	Ilm law)			26. Place of Dea	24e. Wes	en eutopsy ormed?	3 Prote	ore autopsy findings olleble prior to nopletion of cause leath?	
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no pe combieren	examiner? 1 Yes 2 No 27. Menner of Deeth 1 Neturel 5 Pen 2 Accident inve	Hospital 1 In Ir	ipatient ZWE	8b. Time of Injury	28c. Inju Wo M 1	her: 4 Nursing H	24e. Wesperfilled the Check only ome 5 Res 28d. Describe	en eutopsymmed? Yes 2 No one) dence 6 Other	24b. We ever correctly of a limit of the correct of	ore autopsy findings olleble prior to impletion of cause death? Yes 2 No	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death Month 3. Time of Death **Physician** George Joseph Eckerl March 16 1999 4:54 AM /Medical 4a Facility Nama (If not institution, give street and number)
Good Samaritan Hospital 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore City 7. Age (In yrs. last birthday) Hunder 24 Hrs. 8. Data of Birth 9. Birthplaca (St. Month, Day, Year) 9. Birthplaca (St. Month, Day, Year) Maryland If Under 1 Year 9. Birthplaca (State or Foreign 5 Social Security Number 705-05-3534 6. Sex. 1 ☑ M 2 ☐ F **Funeral** Days Months Yrs. Director Usual Rasidence of Decedent the Meryland 10c. City, Town or Location Baltimore City 10a. Stata 10b. County 10d. Inside City Limits 7 is marked other than "natural", or home 23s or 28a-f show traumetic event, the Medical Examiner must be notified at MD 1 XYes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21234 2720 Kildaire Drive Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) Raca - Amarican Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effect.
Department of Heelth and Mental Hygiene.
Important: if Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examples. 1 ☐ Yas 2 ☐ No If Yes, Giva 1 ☐ Nevar Married 2 ☑ Married Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Meat Packer Food Processing 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be Unknown Unknown 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 2720 Kildaire Drive Baltimore, Maryland Dora C. Eckerl/Wife 20b. Place of Disposition (Nama of cometery, crematory or other place)
Parkwood Cemetery 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State 3/18/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Sarvice Licens 22. Nama and Address of Fecility Inc. 5305 Harford Road Leonard J. Ruck, Inc Baltimore, Maryland 23a. Part1. Enter the disease, or complications that course the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on such line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner burial-transit physicien and the burial-tran Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Box 68760 Physician/Medical Due to (or as a consequence of): 88 980 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 200 signed by t d be detect 3 Probably 4 D⊌hknown 1 Yee 2 No by

Completed Be

Certification: To

peen hes certificate To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifical completely filled in by the funeral director,

State Registrar

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24b. Were eutopsy findings availabla prior to complation of causa of death? 24a. Was an autopsy performed? 1 Yas 2 4 N 1 Yas 2 No 25. Was case referred to medical axaminar? 26. Place of Death (Check only ona) 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 1 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Matural 5 Pending invastigation 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be datamined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data end piece, and due to the cause(s) and manner stated. (Check only one)

29c. License number

P1139

29d. Date signed (Month, Day, Year)

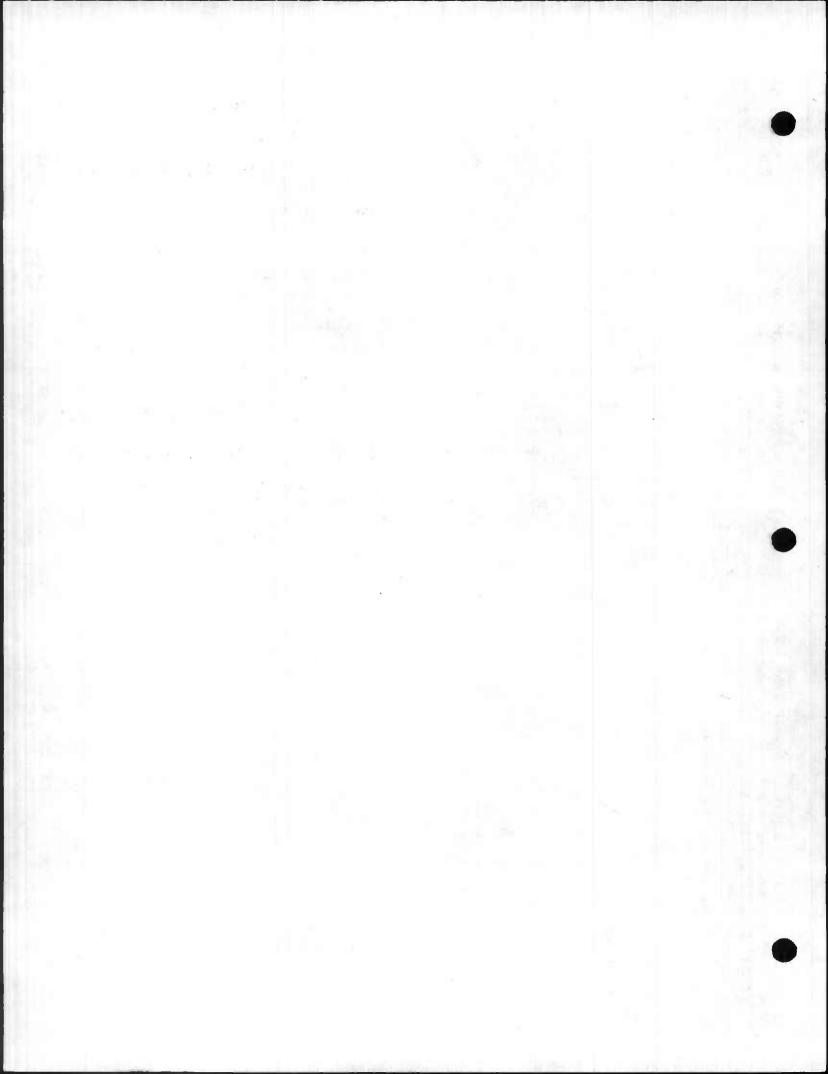
chul 30. Nema and address of person who completed cause of death (Item 23a) (Type, Print) Lock Raven Skaf 5601

31. Data filed (Month, Day, Year, MAR 1 8 1999

29b. Signature and titla of certifier

32. Registrar's Signature

altrine MD 21239

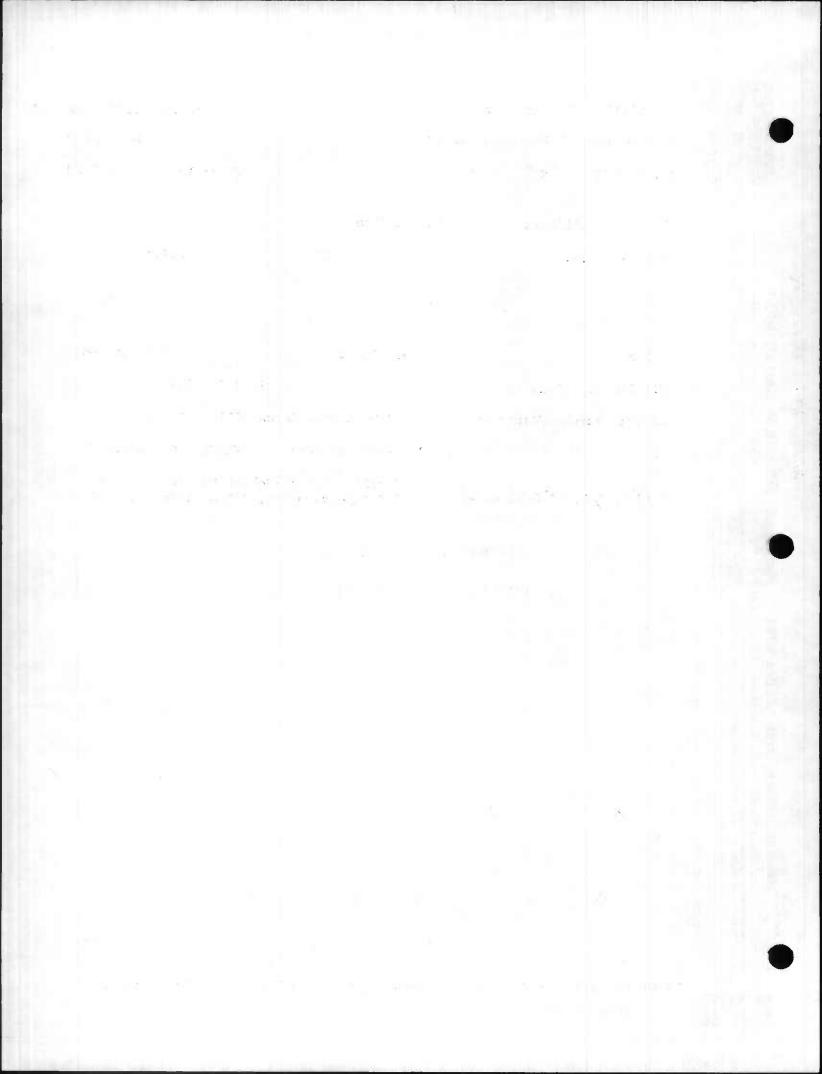


State of Maryland / Department of Health and Mental Hygiene

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Physician	1. Decedent's Name (First, Middle, Last)							2. Date of De Month	Day	Year 3. T	ime of Death	
/Medical	William H. Eyler Jr.							MARCH			04 AM	
Examiner												-
	Saint Joseph Medical Center						TOWS (altimo		1
uneral irector		Months Days Hours Min. (Month, Day, Year) Co								9. Birthplace (S Country) Marylan	State or Foreign d	
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al, or items 23a or 28a-f show Examiner must be notified at by Funeral Director	5								10	Yes 2 No	I	
be notified Director	MD 10e, Street and Nu	Baltimo	re		atonsvi	10f. Zip Code			10g. Citizen of 1		Α	I
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	17. Father's Neme	(First, Middle, Lest)					18. Mother's Nar			ne)		I
2	William	m H. Eyler	, Sr.				1	e (Otke				Į
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complately filled in Medical Cert	29a. Certifier (Check only one)	Certifying Phys		of examina							ause(s)	
complately filled Medical Ce	29b. Signature end	title of certifier	5.1.2 1716/17/01			29c. Lice	nse number		29d. Date signe	ed (Month, Day,)	(ear)	-
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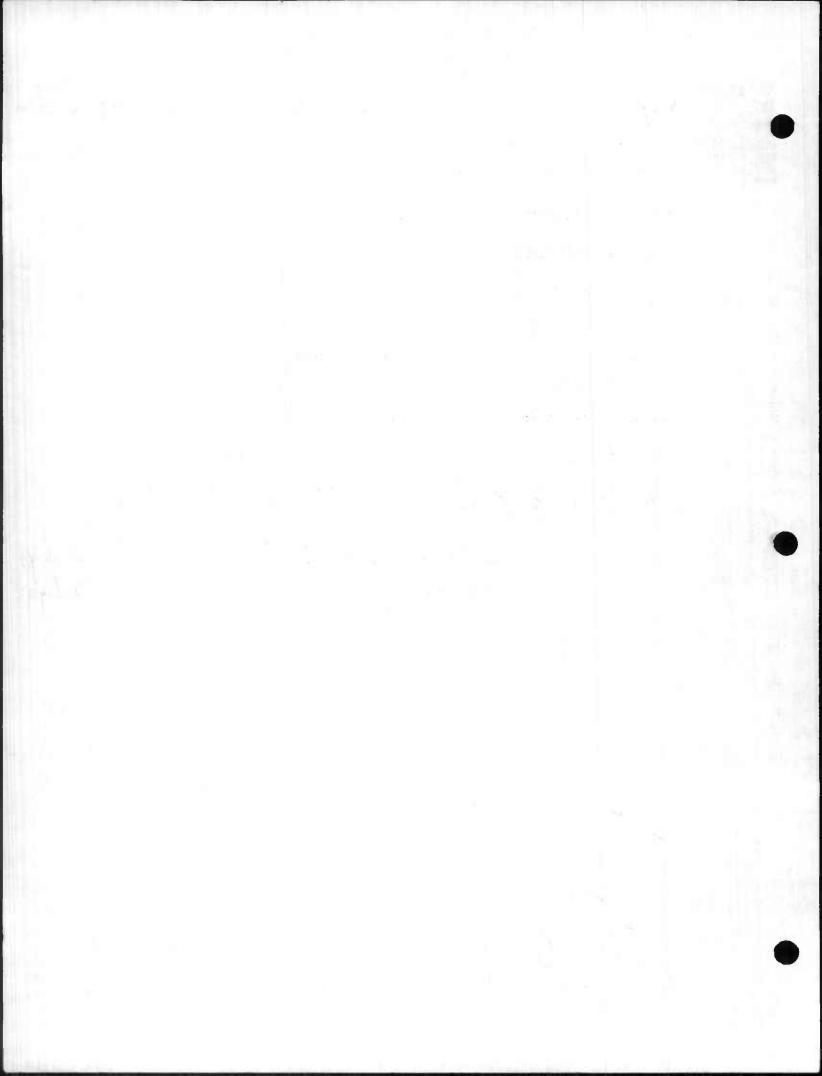
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month ROBERT 25 am March 16 /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Good Samaritan Hospital Baltimore N/A Hours Min. 8. Date of Birth (Month, Dey, Yee 1-24-29 5. Sociel Security Number If Under 1 Year Birthpleca (State or Foreign Country)
 W VA 7. Age (In yrs. lest birthday) **Funeral** ntry) VA Days M 2□ F 216-28-4383 70 Yrs Director Usual Residence of Decedent the Maryland 10e State 10b County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner mant be notified at MD Baltimore Raspburg Director 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 5610 Greenhill Ave. 21206 USA Funeral death 12. Was Decedant Evar in U,S. Armed Forces? 1 □XYes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puarto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Evant 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: white þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 9 0 Truck Driver Asphalt Co. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Meiden Surname) Be Ray R. Eskey Sr. Lorena A. Hushion 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 5610 Greenhill Ave. Baltimore, MD 21206 19a. Informent's Name/Relationship (Type, Print) Judith A. Eskey/wife 20b. Place of Disposition (Name of cemetery, cremetory or other place)
Metro Crematory 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Wemetion 3 ☐ Removel from Stete 3-18-99 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama end Address of Eacility Cvach/Rosedale Funeral Home 21. Signal of Funerel Service Licenses 1211 Chesaco Ave. Rosedale, MD 23a. Pert1. Enter the disaase, or complications that caused the death. shock, or heert failure. List only one cause on each line. Do not enter the mode of dying, such es cardiac or respiratory errest, Approximete Intervel Betw Onset and Death **Physician** /Medical Immediete Ceuse (Final disaesa or condition resulting in death) Examiner Examiner The lew requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest and P.O. Box 68760, ettending physiclan for use es the burie Physiclan/Medicai Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 □ Probably 4 □ Unknown bengis Division of Vital Records, þ 24b. Wara autopsy findings aveilable prior to completion of causa of deeth? Be Completed 24e. Wes en autopsy performed? page 2 s 1 1 Nos 2 No 1 Yes 2 No the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Diractor: After this certific completely filled in by the funeral director. 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidence 8 Other (Specify) 1 Yas 2 No 1 4mpatiant Medical Certification: To 2 ER/Outpetient 3 DOA 27. Menner of Deeth 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 1 Deturel 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 | Homicide 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Yeer) Baltimore 1D 21239 Lock

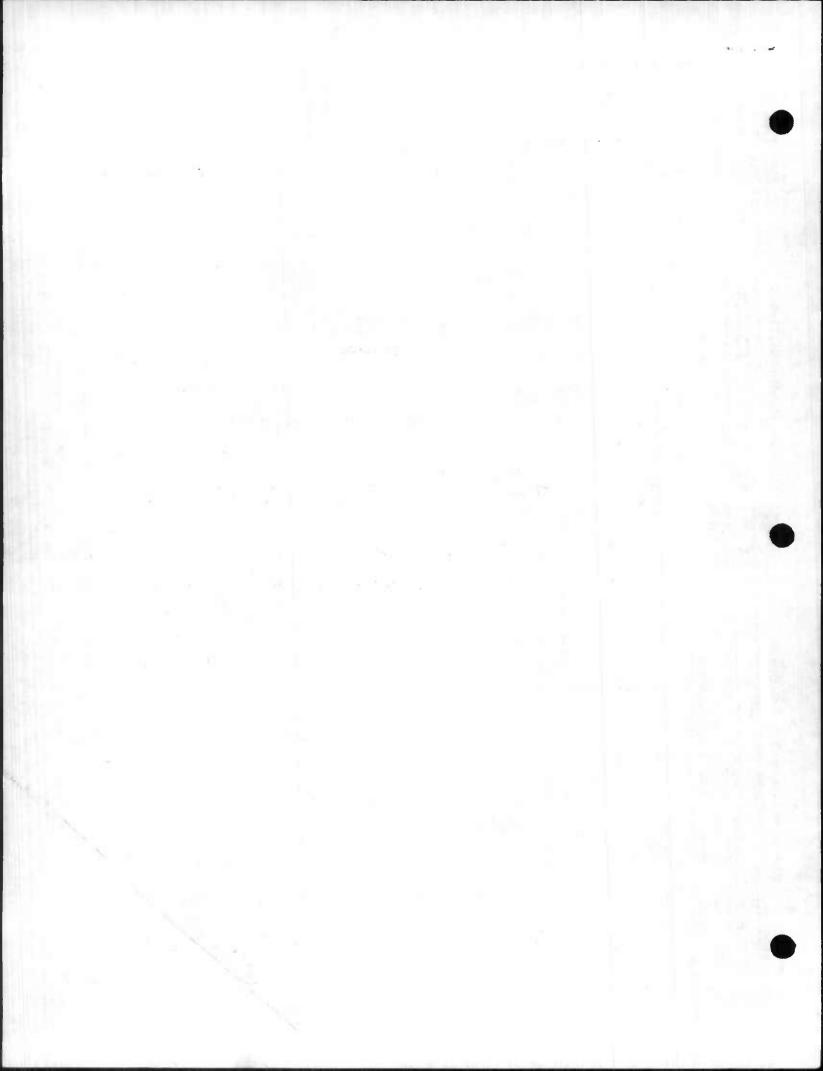
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32. Registraris Signetyre

State Registrar



	Item:1 per M.D G-769 3/ 1. Decedent's Name (First, Middle, Las		Ce	rtificate of	Death	2. Date of Dea		V	3. Time of D	leath
Physician /Medical	Ida Marie Frank 4a Facility Name (If not institution, give	street and number)			4b. City, Town, or L		6, 1999 4c. County of	Year f Deeth	10:03	AM
Examiner Funeral Director	Good Samaritan I 5. Social Security Number 6. Se	Hospital 7. Age (In)	yrs. last birthday 75 Yrs.		Baltimo		N/A Year)			Foreign
ð u	Usual Residence of Decedent 10a. State 10b. County	10c	City, Town or L	ocation				10	d. Inside City	Limits
pointer must be nomited at /	Maryland N/A		Bal	ltimore					tX Yes 2	□ No
Dire	10e. Street and Number			10f. Zip Code			log. Citizen of W			
by Funeral	3300 Rosalie Avenu 11. Merital Stetus 1 Never Merried 2 Married 3 M Widowed 4 Divorced	12. Was Decedent Ever I Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	n U,S. 13.	21234 Was Decedent of HIYes, specify Cub □ Yes 2X No	dispante Origin? (S) an, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	United 14. Race Black Specify:	- America , White, e	n Indian, tc.	
Completed I	15. Decedent's Edi (Specify only highest grad Elementery/Secondery (0-12)	ucation	(Give	edent's Usual Occup e kind of work done DO NOT use retire	pation during most of word d)	king	16b. Kind of Bus	iness/Indu		
Be	17. Father's Neme (First, Middle, Last)				18. Mother's Nam		Maiden Sumame			
To	Joseph A. Hilte 19e. Informant's Name/Reletionship (T)	ype, Print)	19b. Mail	ing Address (Street		I. Peaco		State, Zip (Code)	
	Joseph C. Frank	Son	-	7 Oakcres			re, MD			
	20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremetion 3 ☐ I		 b. Place of Disp cemetery, cre 	osition (Name of matory or other pla		Dete	20c. Location - C			
	4 ☐ Donation 5 ☐ Other (Specify,	Н		Service Co		3/19/99	Towson,	Mary	land	
200	VUUMUUS H	™ Timothy H	a,a.,	eonard J 5305 Harf	. Ruck, I	nc. Fund	eral Home	e 2121/		
Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due t	conding of or as a conse	B Cancer W quence of):	anes8 Thabdown and			A Cagal	Smulti	rs
Physic	Part II. Other significant conditions con	ntributing to death but not	resulting in the	underlying cause gi	ven in Part I.	23b. Did to	obacco ues cont		the cause of ably 4 🗆 Ur	
Completed by				I my i lis		24a. Wes a	n autopsy med?	con	re autopsy fini ilable prior to apletion of cau eath?	
	25. Was case referred to medical				00 Div. (D.	1 🗆 Y	,	1 🗆	Yes 2□ N	io
To Be	examiner?	Hospital:	2 ER/Outpatie	nt 312 DOA OU	har:	th (Check only or ome 5 Resid		r (Specify,)	
Certification:	27. Manner of Death 1 Netural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be	28a. Date of Injury (Month, Day Year 28e. Pleca of Injury - A		M 1□	ny at rk? IYes 2 □ No		ow Injury occurre		Pouto Numbe	or.
	4 Homicide determined	building, etc. (Sp.	ecify)			City or Tow				
edical		aician: To the best of my ner: On the basis of exam and manner steted.								
Me	29b. Signeture and title of certifier	20		29c. Licens	se number	1	29d. Date signed	(Month, D	ay, Year)	
	· Paul le	long no-		DI	6587		3/17	199	7	
State istrar	30, Name and address of person who con Chang, V 31. Dete filed (Month, Day, Year) MAR 1 8	7.9 560/ 32. Registrar's Si	Lozh gnature	Raven I	Block, I.	Balt, me	re, MD	21	239	



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month fein 8 AM, March DelmA 16 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY 11814 ROSALINDA DRIVE POTOMAC If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month Day APRIL 4 9. Birthplace (State or Foreign Days Months 1□ M 2₽ F Hours YT925 NEW YORK 73 125-18-3529 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits No 2 No MONTGOMERY MD POTOMAC 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20854 11814 ROSALINDA DRIVE U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 AMarried Specify: WHITE 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BLEYER INDUSTRIES OFFICE MANAGER 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOSEPH GOLDMAN TILLIE FEINMAN 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 11814 ROSALINDA DRIVE POTOMAC MD. 20854 MORRIS FEIN /HUSBAND 20b. Place of Disposition (Name of cemetery, cremetory or other place)
BETH MOSES CEMETERY. 20c. Location - City or Town, Stete 20a. Method of Disposition Dete DEXBurial 2 Cremetion 3 X Removel from State 3/18/99 PINELAWN NY. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
SOL LEVINSON & BROS. INC. 21. Signeture of Funeral Service Licen 23a. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or pearl feilure. List only one cause on each line. 8900 REISTERSTOWN ROAD PIKESVILLE MD 21208 Approximete Intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) weg SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (of as a consequence of) Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Wes an eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? 212 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Magner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Netural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only

Division of Vital Records, P.O. Box 68760, or Attanding Physicien: The law requires that the death certificate be associated

Physician

/Medical

Examiner

Funeral

Director

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Pages 1 and 2 should be filed nert of Health and Mental Hygis est. If Nem 27 is marked other

Department of Health an Important: If Nem 27 is any Injury or other trau 2058.

Physician /Medical

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To the Howithin 24 To the Fu Examiner

Physician/Medical

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Certification: To

72 hours after

Baltimore, Maryland 21215-0020

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Sene 32. Re

32. Registrar's Signature

Sporty

29d. Date signed (Month, Dey, Year)

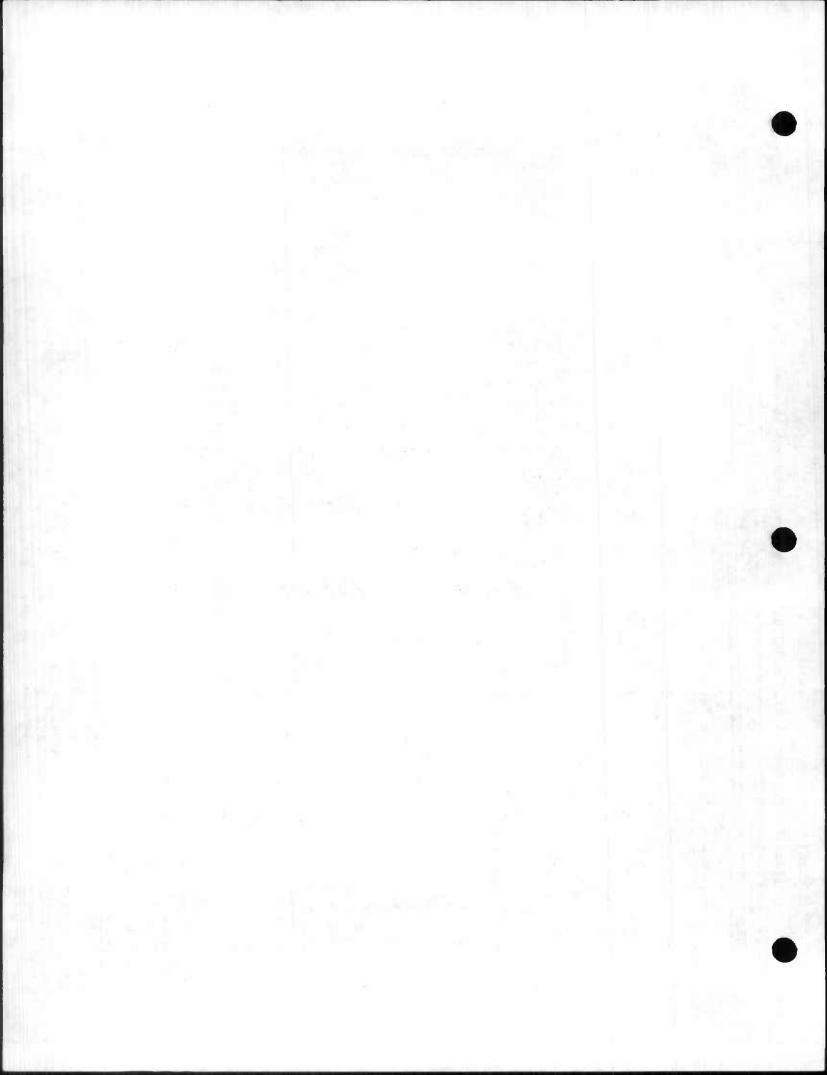
Hary Comso MI

29b. Signature and title of certifie

30. Name and address of person who comp

(Non-20a) (Type, Print)

10016 -



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Defe of Death 3. Time of Death Month FENSTERWALD SEYMOUR MARCH 1999 07:31AM 13 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL N/A 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Defe of Birth (Month, Day, Year) Deys Hours 82 Yrs. 229-10-1432 AUG. 25, 1916 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD BALTIMORE BALTIMORE 10e. Street end Number 10g. Citizen of Whet Counfry? 10f. Zip Code 7 SLADE AVENUE #412 21208 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 12 BUYER HOCHSCHILD KOHN CO. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) JULIUS B. FENSTERWALD GERTRUDE R. ROTHSCHILD 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) BELLE FENSTERWALD / WIFE 7 SLADE AVE. #412 - BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW CEMETERY 3/16/99 REISTERSTOWN, MD 22. Name end Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - BALTIMORE, MD 21208 23a. Part1. Enter the disease, or complication. Caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one care on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA 9 DAYS Due to (or es a consequence of). Due to (or as a consequence of): Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were eutopsy findings evailable prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No 28. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

rei', or items 23a or 28a-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If New 27 is marked other than "naturel", or Nerma 23a ship injury or other treumatic event, the Medical Examine massing.

Baltimore, Maryland 21215-0020

Director

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Physician/Medical Examiner attending physician and for use as the burial-transit USe signed by the a by Completed

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To the Hosp within 24 hos To the Fune completely fi

the death certificate be executed s certificate has b director, page 2 s this funerai

Division of Vital Records, P.O. Box 68760, Hospital or

Registrar

Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2No Inpatienf 2 ER/Oufpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. fnjury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, streef, factory, office building, etc. (Specify) 4 Homicide Certifying Phyalcien: To the best of my knowledge, deeth occurred at the time, date end placa, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steled. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) SUSA N , MD

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JOHNS HOPKINS HOSPITAL

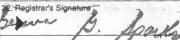
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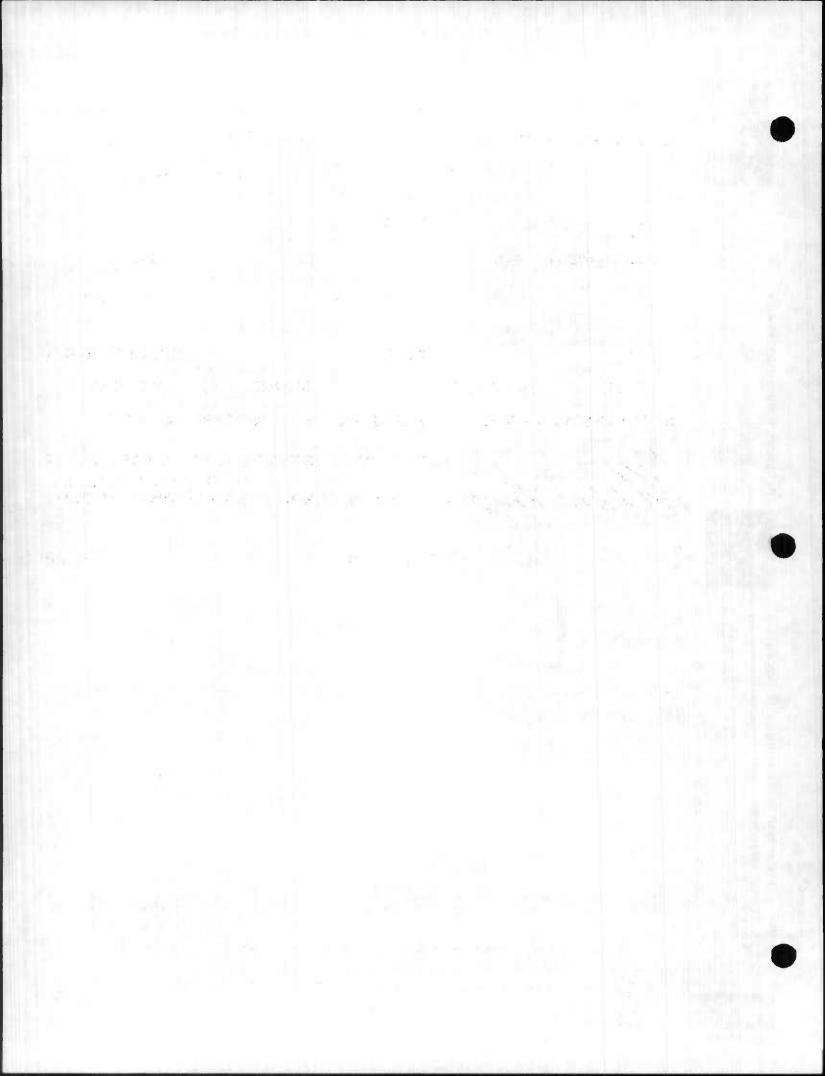
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31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** 8:15 p.m. Joy F. Gundersdorff 3 99 16 /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner Edenwald Baltimore Towson If Under 24 Hrs. 8. Dete of Birth (Month, Dex 1, 1901) 9. Birthp Cour August 31, 1901 Iowa If Under 1 Yaar Birthplece (State or Foraign Country) 5. Sociel Security Number 7. Age (In vrs. lest birthday) **Funeral** 1 M 200 F Months Deys 008-24-9451 97 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. Steta 10b. County 10c. City, Town or Location 1 Yes 2 No Directo Maryland Baltimore Towson f is marked other than "natural", or items 23s or 25s-f traumatic event, the Medical Examiner must be notified 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 800 Southerly Rd. 21286 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14 Rece - American Indian 11. Marital Status Black, Whita, etc. 1 ☐ Yes 2 XNo If Yes, Give Yaar or Dates: 1 □ Nevar Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify: White by 3 ☐ Widowed 4 X Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast greda completed) 16b. Kind of Business/Industry College (1-4or 5+) Etementary/Secondary (0-12) Hygiene. Teacher/Dietician Education is marked other 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fathar's Nema (First, Middle, Last) 8 and Mental James Fitzsimmons Katherine Stine should 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Department of Health reportant: If Nem 27 Weaver Daughter 18 Mayapple Ct. Baltimore, Maryland 21286 ca of Disposition (Name of Date 20c. Location - City or To Barbara 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 20b. Placa of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stata Pages 3/20/99 Baltimore, Maryland Lorraine Park 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signatura of Funerel Service Licanses 22. Name end Address of Fecility Mitchell-Wiedefeld Home Inc. Columnt 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each tine 6500 York Rd. Baltimore, Md. 21212 Approximete Intervet Between Onset and Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting tn death) Examiner Examiner Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or injury that Initieted events rasulting In daeth) Last Box 68760, physician certificate be Physician/Medical the Due to (or as a consequance 88 USB The law requires that the death 23b. Did tobacco usa contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. P.O. the 2 1 Yes 2 No 3 Probably 4 Unknown Records. by 24b. Were eutopsy findings eveilable prior to 24e. Wes en autopsy performed? Completed peen s completion of cause of deeth? 788 cartificate l 1 Yes 2 NO 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Lo 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpettent 3 ☐ DOA this funeral 28e. Date of tnjury (Month, Dey Yeer) 27. Manner of Deeth 28d. Describe how tnjury occurred Certification: 28b. Time of After 1 Neturet 2 Accident 5 Pending investigation 1 Tes death. within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) filled in by 4 | Homicide 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, data end pleca, and due to the cause(s) end manner as stated. 2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end pleca, end due to the cause(s) end manner stated. edicai 29a. Certifier (Check only one)

29c. License number

1120 N. Rollin

29d. Data signad (Month. Dav. Year)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Registrar

29b. Signature and title of certifier

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31. Dete filed (Month, Dey, Year)

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30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

1999

32. Registre

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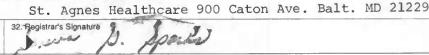
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time # Deeth Month **Physician** Edward Girard Gray March /1 /Medical 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City St. Agnes Hospital N/A Il Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number HILLER 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** Hours Months 1₽M 2□F Yrs. 76 213-16-1203A Director Oct16,1922 Maryland Usual Residence of Decedent with the Marylend 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or itsms 23s or 28s-f show the Medical Exercines must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Catonsville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 511 Westside Blvd 21228 U.S.A Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Stetus filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII altimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health end Mental Hygiena. Important: If item 27 is marked other than "na any injury or other traumatic event, the Mealing. Elementary/Secondery (0-12) College (1-4or 5+) Manufacturing 12 Production Planner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be THelma Sippel Ellwood G. Gray 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 511 Westside Blvd. Catonsville, MD 21228 Beverly E. Gray/Wife 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 Burial 2 ☐ Cremation 3 ☐ Removel from State Mar15,99 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park 21. Signeture of Funeral Servica Licansee 22. Name end Address of Fecility Sterling-Ashton-Schwab Funeral Home, Lully lacks 736 Edmondson Ave. Catonsville, MD 21228 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting In death) Examiner Examiner certificata be axecuted the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Last and physician Physician/Medical Due to (or es e consequence of): been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24e. Wes en eutopsy 1 ☐ Yes 2 ☐ No 1 Yes Aftar this certificate Be 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1. Neturel 5 Pending Investigation aftar death. Director: Al 1 Yes 2 No 2 Accident 6 Could not be determined To the Hospital or Atte within 24 hours aftar de:
To the Funeral Directo completaly filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) end manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier edical 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) al Ballo

State Registrar 31. Dete filed (Month, Dey, Year)

MAR 1 8 1999

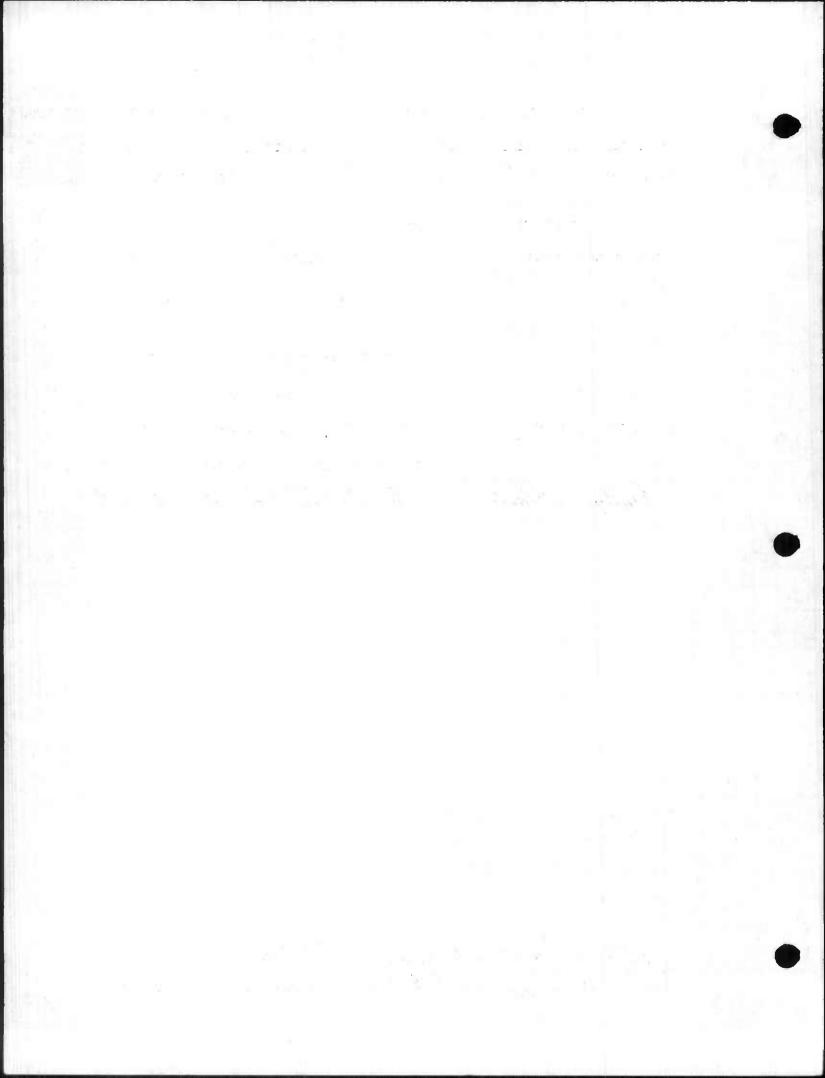
30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O O O O O O O

nysician					Cer	tificate of	Death		Reg. No.		
		me (First, Middle, i	Last) DARIA GIL	DEA D	C W			2. Date of De Month	Day	Year	3. Time of Death
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Director	10e. Street end N	lumber				10f. Zip Code			10g. Citizen of V	Vhet Count	ry?
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by Funeral		s erried 2 Married I 4 Divorced	12. Wes Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? ⊠ No		vas Decedent of I Yes, specify Cub ☐ Yes 2 No	Hispanic Origin? (S en, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	Specify	e - America k, White, e	tc.
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To Be C		GILDEA							, maiour ourrorn		
To		Name/Relationship	(Type, Print)		19b. Meilin	g Address (Street	MARY t and Number or Ru	IVEY rel Route Numb	er, City or Town,	State, Zip	Code)
	THE SIST	ERS OF M	ERCY			BOX 1144	08 BALTI	MORE, M	ID 21202		
			Removal from Sta	ite	emetery, crem	sition (Neme of natory or other ple CEMETER		Date 3/19/99	20c. Location - WOODLAW		
DOCE.	21. Signature of	Funeral Service Lic	Hack	_	ST		ess of Facility SHTON-SCH SON AVENU				
burial-transit all Examiner	diseese or condi- resulting in death Sequentially list of any, leading to cause. Enter Lin.	conditions,	. Athe	Dua to (or 105 C) Sue to (or 105 C)	r as a consequence as a consequence	vertice of): Clu uence of);	dirva	seula	r dise	ase	years
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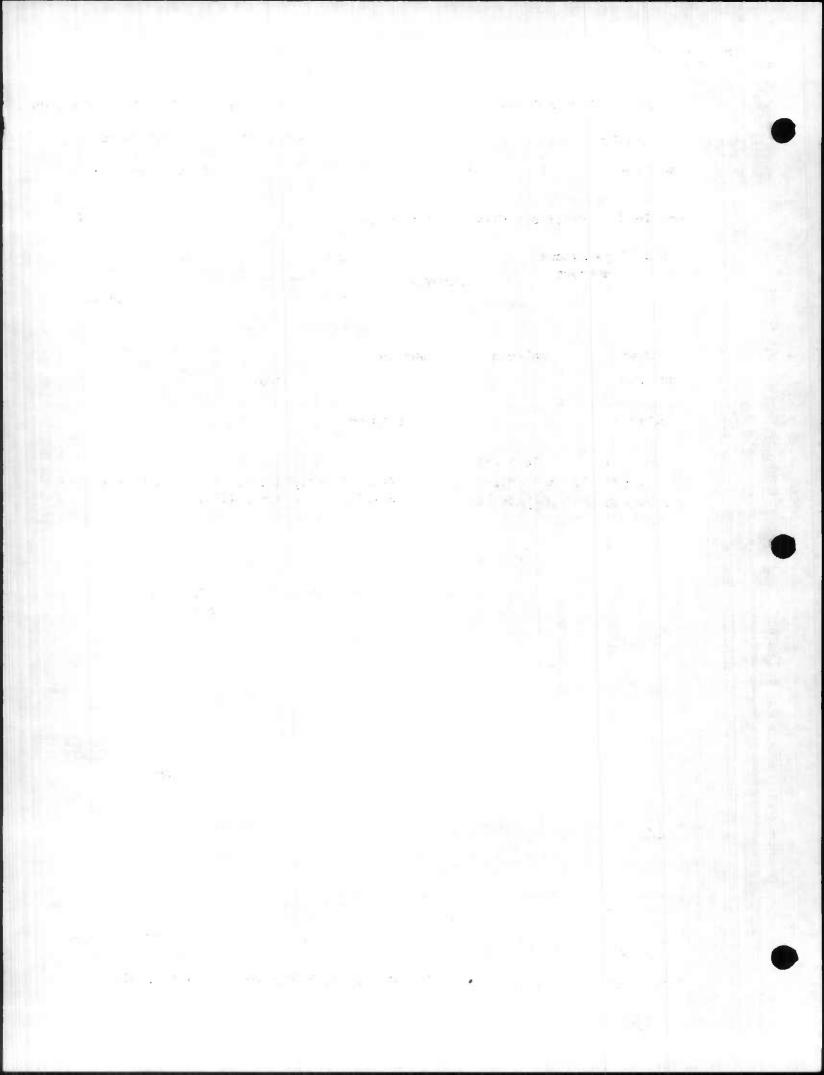
State of Maryland / Department of Health and Mental Hygiene Q 08631

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	1. Decedent's Nama (First, Middle, Last	0	- 1111					Data of De Month		Yea		ne of Death
Physician /Medical	Julius Edward	Guess					F	EB.	23,	1999	135	52 PM
Examiner	4a Facility Name (If not institution, give	street end number)				4b. City, Tow				County of D		
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Funeral Director	5. Social Security Number 6. Se unknown	7. Age (In	yrs. lest birti	rs. If Und	er 1 Year Days		Min. 8. I	Date of Birt (Month, Da April	h y, Year) 6, 1	9. E 1929 t	Birthplace (St Country) Inknown	ete or Foreign
p .	Usual Residence of Decedent 10a, Stata 10b, County	10	c. City, Town	or Location								le City Limits
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Ne M	10e. Street and Number	nore City	раті	timore	ip Coda			-	10a Citiz	en of What	Country?	
Dir Dir	2513 Riggs Avenue										oountry !	
eath	11. Marital Status unknown		in U.S.		1216 edent of	Hispanic Origi	n? (Specify		U.S.A		merican india	n,
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2-0 72 ho	15. Decedent's Edu (Specify only highest grad	ucation	16a.	Decedent's Us	ual Occu	pation during most	of working		16b. Kin	d of Busine	ss/Industry	
L Z I Z I 3-0. led within 72 ho ygiene. wr than 'nature t, fre Modified Completed	Elementery/Secondery (0-12)	College (1-4or 5+)		life. DO NOT	use retin	ed)	or working		unl	manm		
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antimore, mit. Pages 1 er partment of Hea portant: If Nem; y Injury or other	20a. Mathod of Disposition 1 □ Burial 2 □ Cremation 3 □ Burial 4 □ Donation	Removal from State	Ob. Place of cemeter	Disposition (A crematory of	ame of r other pl	ace)		Pate	20c. Loc	eation - City	or Town, Sta	е
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/Medical Examiner	disease or condition resulting in deeth)	a. CONGOSTI Due b. Hyporr	to (or as a c	onsequence o	f):			Dno!	DVIDS	cum	7	
barbu, ficate be executed physician end is the buriel-trensit edical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that britisted except.)	Due	to (or as a c	onsequence o	f):			Di	407	So		
2 E E E	that initiated events resulting in death) Last	i):										
P.O. BOX net the death cert d by the attending statched for use a		d										
of the de disched f	Part il. Other significant conditions co	ntributing to death but no	t resulting in	tha underlying	cause g	iven in Part I.		23b. Dld	tobacco	use contrib	ute to the ca	
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he lay								15	Yes 2] No	1 Yes	2 No
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Of Vital report of the law physicien: The law rail director, page 2 and director, page 2 is To Be Comp	examiner?	Hospital:	2 ER/Out	patient 3	DOA O	dh a.c.	sing Home			Other (S	Specify)	
OVIVISION OF or Attending Physafter death. Director: After this in by the funeral d ertification: Te	27. Manner of Death 1 Neturel 5 Pending	28e. Dete of injury (Month, Dey Ye			28c. inj		28d	. Describe				
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To th To th comp	29b. Signature and title of certifier	11 .		2		c.M.E					onth, Dey, Ye	
	30. Neme and address of person who co	MWW ompleted cause of death	(Item 23a) /	Type, Print)							., .,,,,	
	h / a A 14	DREVL M			reet,	, Balti	more,	Mary	land	2120	1	
State Registrar	31. Date filed (Month, Dey, Year)	32. Registrar's	Signature	Low	Kal							

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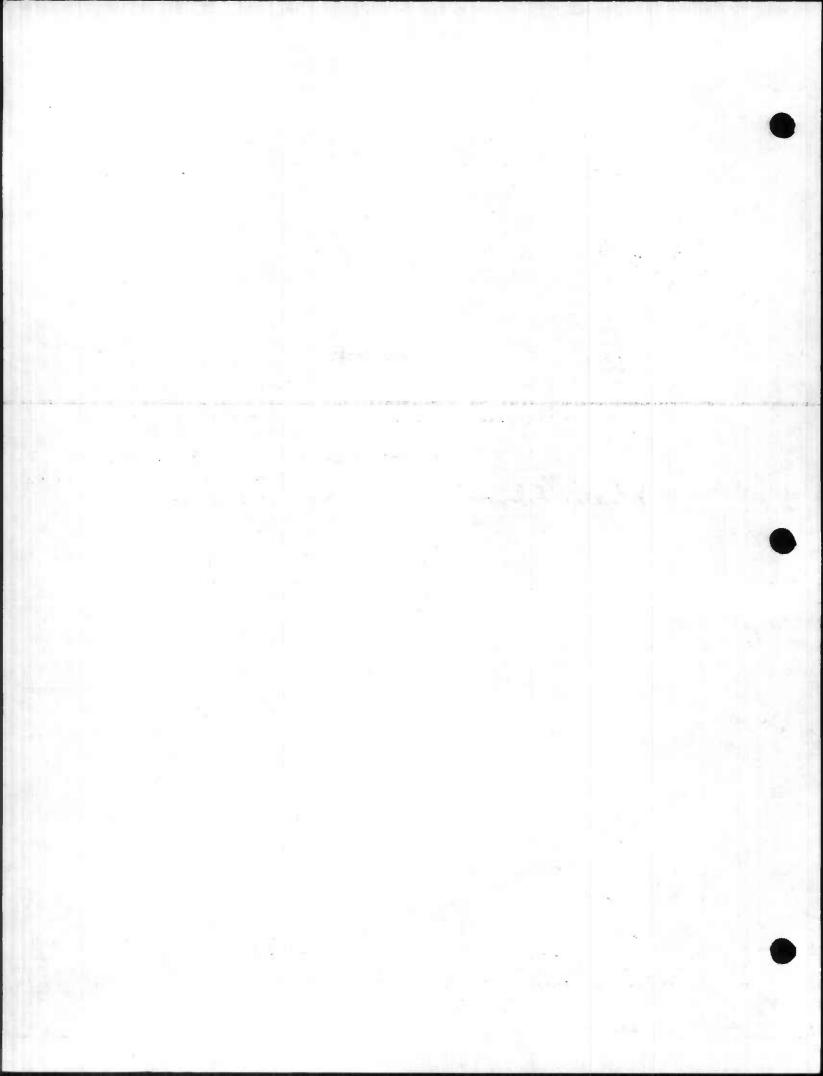
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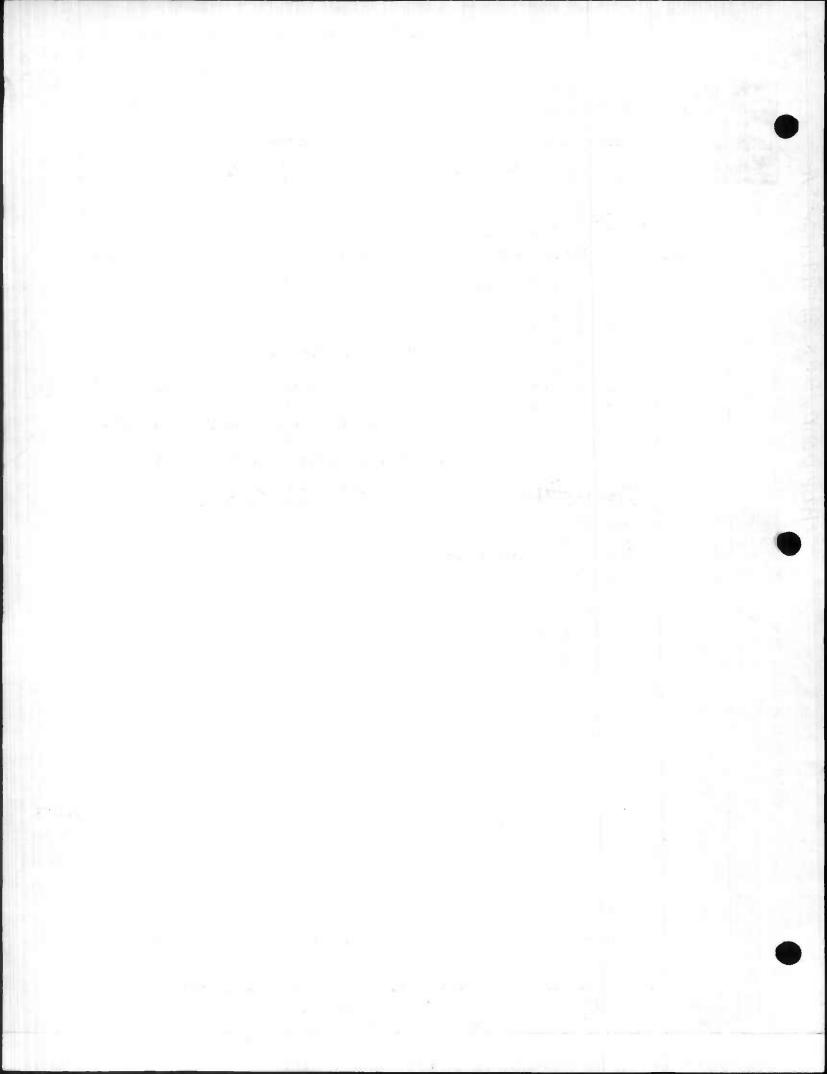
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Physician /Medical	Dorothy Hardy	March	
Examiner		y, Town, or Location of Deeth	4c. County of Death
		altimore	NA
Funeral Director	5. Social Security Number 6. Sex 1 M 2 M 2 M 65 Yrs. Social Security Number 6. Sex 1 M 2 M 65 Yrs. Social Security Number 1 Year If Under 1 Ye		Year) 9. Birthplaca (Stefe or Fi Country) MD
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ms 23a or 28a-f show cround be notified at neral Director	MD NA Baltimore		1 X Yes 2
1 28 Det	10e. Street and Number Apt. 10f. Zip Code	10	Og. Citizen of What Country?
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28 5	11. Merital Status 12. Wes Decedent Ever in U,S. Armed Forces? 1		14. Race - American Indian, Black, White, etc. Specify: Black
P P	130/3.0300		
or than "nature it, the Wedical is Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during tillfle. DO NOT use retired)	most of working	16b. Kind of Business/Industry
then "	Elementery/Secondery (0-12) College (1-4or 5+)	. 93	Word Processor
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Department Important: It any-Injury o	21. Signeture of Funeral Service Licensee 22. Name end Address of Fu	ecility Baltimor	e, Maryland 212
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within 24 hours after death To the Funerel Director: completely filled in by the Medical Certificat	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date to the control of the basis of examination and/or investigation, in my opinion, and menner stated.	te end plece, end due to the ca deeth occurred at the time, de	nuse(s) end menner as stated. ele end placa, and dua to the cause(s)
To the comp	29b. Signeture end title of certifier 29c. License numb		9d. Date signed (Month, Day, Year)
1) 8/1/and 1)30	641 1	March 16 1999
2)	30. Name and address of person who completed cause of death (Item 23e) (Type, Print)		TONOTE TO 1
	RAMESH SABABATH SUITE 308 821 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture	N. EV Taw	T BATIMOREMO
State Registrar	MAR 1 8 1999 Shows B. Sparks		



State of Maryland / Department of Health and Mental Hygiene 9

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Department of Health and Mental Hygiene. Important: if Item 27 Is merked other than "natural", or Items 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be northest at one of the properties of the	1. Decedent's Name (First, Middle, Las Ann Phelps White 4e. Facility Nama (If not institution, giva Stella Maris Hosp: 5. Social Security Number 6. Se 212-26-9132 Usuel Residence of Decedent 10a. Stata 10b. County	Hopwood a street end number) ice 7. Age (In)				4b. City, Town, or		17 1	Yeer 999 of Death	3:25 AM
/Medical Examiner Funeral Director	4e. Facility Nama (If not institution, give Stella Maris Hosp: 5. Social Security Number 6. Sec. 212-26-9132 11	ice 7. Age (In)					Location of Deat	17 1	.999	3:25 AM
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Director	212-26-9132 10 Usuel Residence of Decedent				1	Timonium		Balti		
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mast be notified a must be notified a eral Director		10c	City, Town or I	ocation					10	0d. Inside City Limit
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must be eral Di	10e. Street and Number		ar ormor	10f. Zip C	Coda			10g. Citizen of V	Vhet Coun	tn/?
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or th		2	Publ	ic Rel	ati	ons Dire	ctor	Advert	ising	5
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Ment Ment To To	Charles Vansant Pl	helps				Mildred		Hetz	er	
Due s	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mai	ling Address (Street	and Number or R	urel Routa Numb	er, City or Town,	State, Zip	Code)
or tra	John G. White / So	on	5400	Gunba	rre	el Circle	Longmo	ont, CO	80503	3
of He	20a. Method of Disposition 1 ☐ Buriel 2 ☒ Cremation 3 ☐ I	20	 b. Place of Disp cemetery, cri 	position (Name	of erple	ce)	Dete	20c. Location -	City or To	wn, State
int: H	4 □ Donation 5 □ Other (Specify)	namoval irom State _	reenmou				3/18/99	Baltim	ore,	MD
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s certificate has director, page 2 To Be Comp	25. Was case referred to medical examiner?					26. Pleca of De	ath (Check only	one)		
0 D	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2	ER/Outpatie	ent 3 DOA	Oth	ner: 4 Nursing H	lome 5 ☐ Resi	dence 6 X Othe	er (Specify	HOSPICE
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E 0	3 ☐ Suicida 6 ☐ Could not be 4 ☐ Homicide determined	28e. Plece of Injury - A building, etc. (Spe	t home, farm, s ecify)	treet, factory,	offica		28f. Location (City or To	Streat and Number wn, Stete)	er or Rurel	Route Number,
within 24 hours eft. To the Funeral Directory filled in Medical Cert.	29a. Certifier (Check only one) Certifying Physical Exami	sician: To the best of my iner: On the bests of exam and manner stated.	knowledge, dee ination end/or i	th occurred et nvestigation, Ir	the tir	me, dete end plece opinion, deeth occu	o, end due to the arred et the time,	cause(s) end me data end pleca, a	nner es ste and due to	eted. the cause(s)
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	/Medic	_				tumble H	art			MARCH		999	1700
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-			5. Social Security N	Umber 1 6	Sex 7.	OilAl (Age (In yrs. last	-	If Under 1 Year	ROSE d.A. If Under 24 Hrs.	8. Date of B	~71	1	OR E
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	Physician		23a. Part / Enter t shock, or hea	he disease, or con nt tailure. List only	nplications that caus y one cause on eech	sed the death. D	o not er	nter the mode of d	se Ave. D	or respiratory	arrest,		Approximate tntervel Between Onset end Deeth
}	/Medical Examiner		Immediate Cause disease or condition resulting in death)		a. Pneu	mope	Ril	Toneu	m			1	3 DAYS
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7	Physician: r this certific real director,	0	1 ☐ Yes 2 ☐	•	Hospital: 1 npa			NIL SEL DON			sidenca 6 □Oth		cify)
ion c	te al	ation:	27. Manner of Deat 1 A Naturel 2 Accident	h 5 ☐ Pending investigatio		Dey Year) 28	b. Time of Injury	. W	jury at Vork? □ Yes 2 □ No	28d. Describe	e how Injury occur	red	

Medicai Certificat

nna

3 ☐ Suicide 4 ☐ Homlcide 29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. Licanse number

who completed cause ot death (Item 23a) (Type, Print)

6 Could not be determined

00053617 mD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

State Registrar

22 M.D. 9000 FRANKlin Square DR. BAITIMORG, MARYLAND 21237 31. Date tiled (Month, Day, Yeer)

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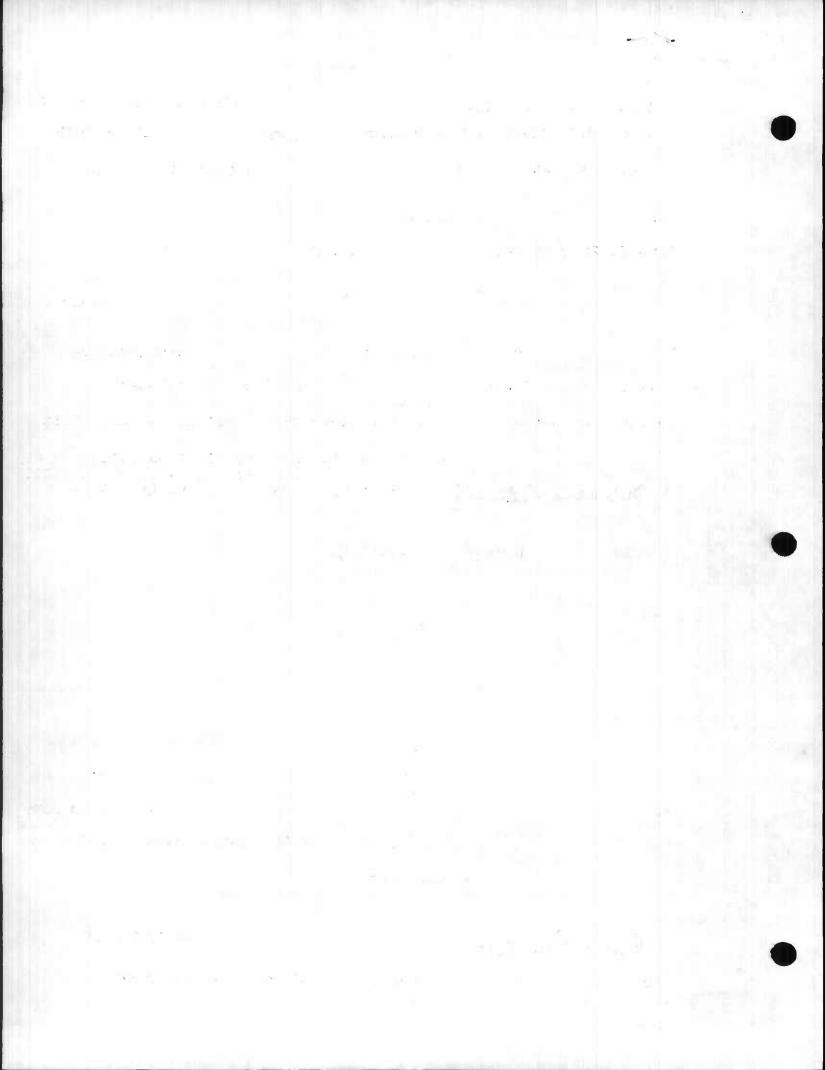
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	Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data							0.0-4-1-	Reg. No. Data of Deeth			3. Time of Death			
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at be noted	10e. S	Street and Nu	. 29th	Stree	t			10f. Zip Cod 212					itizan of V USA	Vhat Count	try?
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Sparket

State Registrar

31. Data filad (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First Middle Last) 2. Dete of Deeth TOHN GON 2325 hr MARY 15 1999 MARCH 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death BALTIMORE May and University of Medical Ceater N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign Days 1 M 2 X F 217 20 8646 Yrs. 31, 1921 Maryland Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 N Yes 2 No N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 1400 McHenry Street 21223 U.S. 14. Rece - American Indien, Black, White, etc. 12. Was Decedent Ever In U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: White 3X Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16h Kind of Rusiness/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 9th Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (not available) Flynn Minnie (not available) 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Joseph Johnson / son 1400 McHenry Street Baltimore, Maryland 21223 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Memorial Park 3/19/99 Glen Burnie, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licensee 22. Name and Address of Fecility Gonce Funeral Home P.A. hilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Baltimore, Md. 23a. Pert1. Enter the diseases shock, or heert failure. Approximete Interval Between Onset and Deeth Immediete Cause (Final disease or condition resulting in deeth) Bacterial Sepsis Due to (or es e consequence of) Due to (or as e consequença of) 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findinge aveileble prior to 24a. Wes an autopsy performed? completion of cause of death?

Physician /Medical Examiner

physician and the burial-trans

signed by the

peen s

has The

certificate

To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

by

Completed

Be

2

Certification:

edical

law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

6

Physician

/Medical

Examiner

Director

28a-f show

Director

Funeral

by

/ la marked other than "natural", or items 23a or 28a-f show traumatic event, the Magical Examinat must be notified as

permit. Pages 1 end 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or item

Baltimore, Maryland 21215-0020

the Marylend

death

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Wes case referred to medical exeminer? 1 Yes 2 No

26. Piece of Deeth (Check only one) ↑ patient 2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred 28c. Injury at Work?

5 Pending Investigation 1 Natural 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 Yes 2 No

281. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier

27. Menner of Death

fortifying Physician: To the best of my knowledge, death occurred at the time, date and piece, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) end manner stated.

29b. Signature and title of certified

29c. License number

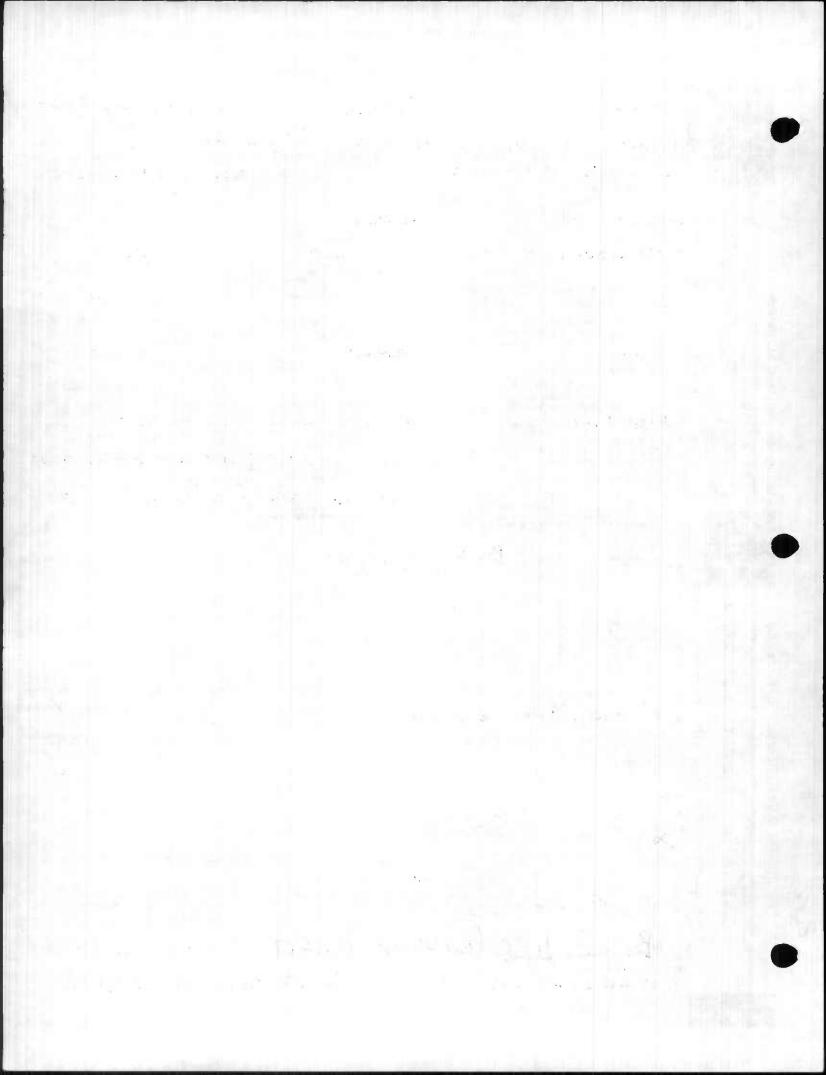
29d, Date signed (Month, Day, Year)

1 ☐ Yes No

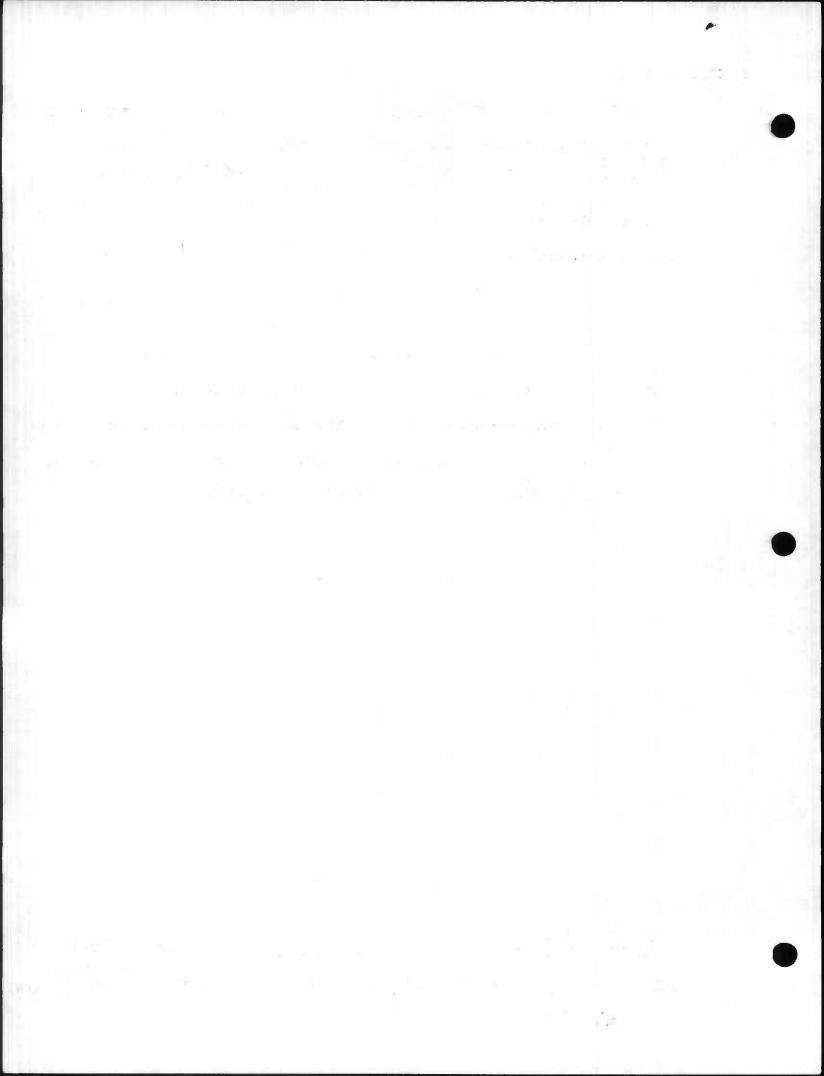
ress of person who completed cause of deeth (Item 23e) (Type, Print)

GREENE LANDRUM ST BACTIMORE MD 21201 31. Date filed (Month, Dey, Year) 32. Registrar's Signature MAR 1 8 1999

State Registrar



AMEND ITE	ML	#5 PER MEO G775 9-8-99 W	ate of Marylar			of Health and of Death	nd Mental H	Hygiene 9	08640	
Physicia /Medic		1. Decedent's Name (First, Middle, Last) S'ADIE K		MIG			2. Dete of Month	Dey	3. Tima of De	
Examine Funeral	er	Fedenwald Retirement 5. Social Sequential Sympton 214-32-0521 6. Sex	Community 7. Age (In yrs.		If Under 1 Y	Towson		Balti Birth Dev. Year) y 26, 1902	9. Birthplaca (Stete or Fo	oreign
Director		Usuel Residence of Decedent 10a. Stete 10b. County		ity, Town or Lo	ocation		Januar	y 26, 1902	Mary Land 10d. Inside City L	
ith the Mary or 28a-f sh	Director	Maryland Baltimore 10e. Street end Number		vson	10f. Zip Co			10g. Citizen of		∆ No
within 72 hours efter death with the Maryland ene. then "natural", or hams 23a or 28a-f show he Medical Examines must be notified at	by Funeral Director	1 Never Merried 2 Married 1	#102-D Ves Decedent Ever in U Imed Forces? Yes 2 2 No Yes, Give Yeer or Detes:		Wes Decedent If Yes, specify 1 ☐ Yes 2 📉	of Hispenic Origi Cuben, Mexican,	n? (Specify Yes or Puerto Rican, etc.)	No- 14. Rec Ble Specifi	ce - American indlen, ck, White, etc.	
	Completed t	15. Decedent's Educatio (Specify only highest grade cor	n	16e. Dece (Give life.		ccupetion one during most o etired)	of working	16b. Kind of B	usiness/Industry	
2 should be filed and Mental Hygis is marked other aumatic event, II	To Be C		eating			Eliz	a Ann Rol			
ss 1 an of Healt Nem 2		19e. informent's Neme/Reletionship (Type, F Ruth Keimig / Daugh 20e. Method of Disposition 1 □ Burial 2 M Cremetion 3 □ Remo 4 □ Donetion 5 □ Other (Specify)	ter-In-Law 20b.	P.O. Piece of Dispo	-	310 234 of plece)		20c. Location	, Stete, Zip Code) clamons, MD 2068 - City or Town, Stete ore, Marylan	
permit. Pages Department of Important: if if any injury or o		21. Signeture of Funerel Service Licensee.		2: N	Neme end A	ddress of Facility	eld Home.	Inc.	and 21212	u
sete be shysicia the bur	an/Medical Examiner	23a. Pert1. Enter the disease, or complication shock, or heart teilure. List only one cell immediate Ceuse (Finel disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underfying Ceuse (Disease or injury that initiated events resulting in death) Last	PAIR Due to (Or as e conse	quence of):				interval Betwee Onset and Dee	eth
d by th	by Physician/Me	Pert II, Other significant conditions contribu	ing to death but not res	sulting In the u	nderlying cause	e given in Pert I.		Did tobacco use co	ontribute to the cause of d	
aw requir	Completed			L			p	/as en eutopsy erformed?	24b. Were autopsy tind available prior to completion of caus of deeth?	se
Physician: this certific al director	To Be	25. Wes case reterred to medical examiner? 1 Yes 2 No Hospi 27. Menner of Deeth Neturel 5 Pending	iel: 1 Inpatient 2 ie. Dete of Injury (Month, Dey Year)	ER/Outpatier		Othor: \	t Death (Check on	Yes 2 No		
or Attendation of Attendations of In by the	Certification	2 Accident investigation	e. Pleca of injury - At h building, etc. (Speci			1 Yes 2 No	28f. Locatio	n (Street end Numi Town, Stete)	ber or Rurel Route Number	Γ,
n 24 hours in 24 hours in Puneral pletely filled	edical	(Check only 2 Madical Examiner: 0	n: To the best of my kno On the basis of exemine and menner steted.	owledge, deet etion end/or in	h occurred et th vestigetion, in r	ne time, dete end my opinion, deeth	plece, end due to t occurred et the tin	the cause(s) and m ne, dete end pieca,	enner as steted. end due to the ceuse(s)	
To the virthin 2 Comple	W	29b. Signature anothtie of certifier	-		0)	cense number	8	29d. Dete signe	d (Month, Dey, Year)	
State Registra		30. Name/end address of person who comple 31. Dete filed (Month, Dey, Yeer)	ted cause of death (Ite	518	Print) CATIL	2 MBA	מ צונה	UMB) L	21090 -11090	7



Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vaai FRANCES GERTRUDE 6:10 KARLIN 1999 PIV MARCH 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 7. Age (In yrs. last birthday) If Under 1 Year Months Days ROCKVILLE OTOMAC VALLEY MONT GOMER. If Under 24 Hrs. 8. Date of Birth JANON 26 1907 6. Sex 9. Birthplace (State or Foreign 1□M 2⊠F 92 Yrs. 087-01-9033 NEW YORK Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No MONTGOMERY CHASE CHEVY 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 20815 4615 NORTH PARK AVE. APT 1109 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, atc. 1 Never Married 2 Married Specify: WHITE 1 Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY PRIVATE 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maidan Sumame) AARON KARLIN ANNTE HILLMAN 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) LORI KRIEGER /NIECE 4615 NORTH PARK AVE. # 1109 CHEVY CHASE MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, Stata cemetery, crematory or other place BETH EL CEMETERY 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/14/99 WESTWOOD NEW JERSEY 21. Signature of Funeral Service Licer 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKES 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, of heart failure. List only one cause on each line. 8900 REISTERSTOWN ROAD PIKESVILLE MD 21208 Approximata Interval Between Onset and Death Immediata Causa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24a. Was an autopsy parformed? 24b. Were autopsy findings available prior to complation of cause of death? 1 ☐ Yas 2 ☐ No 25. Was case refarred to medical examiner? 26. Place of Death (Check only ona) Other: 1□ Yes 35 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 28b. Time of 28c. tnjury at Work?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

must be notified at

Items 23s

"natural", or

Peges 1 and 2 should be flied within nant of Heelth and Mentel Hygiene. In: If Item 27 is marked other than " try or other traumatic event, its Menter of the traumatic event, its Menter or other traumatic event, its Men

the Medical

Director

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Completed

8

MD

the Meryland

deeth with

72 hours after

Baltimore, Maryland 21215-0020

Examiner physicien end the burial-transit Box 68760. Physician/Medical P.O. signed by by Completed Hospital or Attending Physician: Be Medicai Certification: To this After

24 hours after deeth.

Records. of Vital Division

To the To To the F

State Registrar

5 Pending invastigation

6 ☐ Could not be detarmined

2 Accident

4 Homicide

(Check only

3 ☐ Suicide

29a. Cartifier

Therese The

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

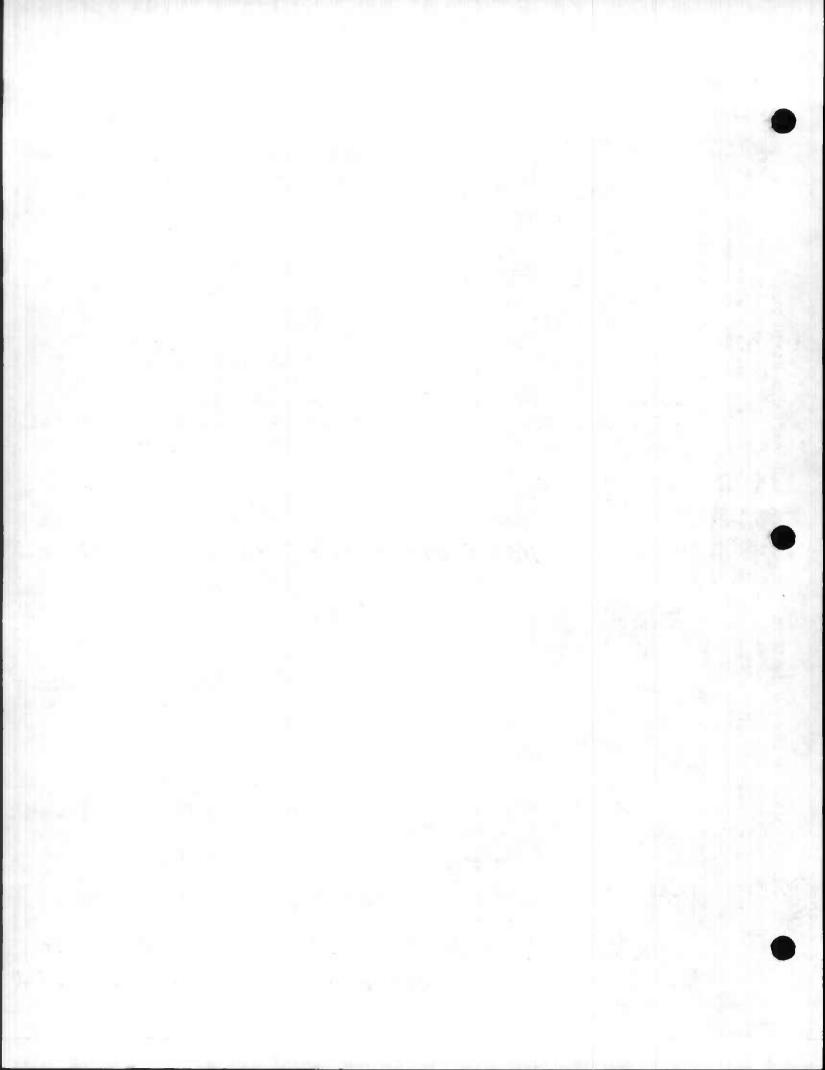
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ath (Item 23a) (Type, Print)

WALTER E-GOOZH SILVER 3PRING MD 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signatura

🔼 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to tha cause(s) and mannar as stated.



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended#23apt2 persPhy G769 3/18/99 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1999gar Raymond H. Knobbe March 8:35 A.M. /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Collington Life Care Community Mitchellville Prince George's If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. lest birthday) **Funeral** Birthplace (State or Foreign Country) XXM 2 F Months Yrs. Director 509 14 0610 85 Jan. 23, 1914 Kansas Usuel Residence of Dacadent 10b. County ms 23a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits Director Yes 2 No Prince George's Maryland Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 10450 Lottsford Rd. 20721 United States death Funeral 12. Was Decedent Ever in U,S. Armed Forces? X⊠Yes 2 □ No ff Yes, Give Year or Deles: 41-45 items 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 'netural', or iter Black, White, etc. 72 hours after 1 Never Married X2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within al Hygiene. Elementary/Secondary (0-12) Coilega (1-4or 5+) Administrator C.I.A. 17. Fathar's Name (First, Middle, Last) permit. Peges 1 and 2 should be file Depertment of Health and Mental Hy Important: if Item 27 is marked oth any linjury or other traumatic event potes. 18. Molher's Name (First, Middle, Maiden Sumame) Henry Knobbe Mary Kathman Lo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) Mary L. Knobbe Wife 10450 Lottsford Rd. Mitchellville Maryland 20721 20b. Place of Disposition (Name of cametery, crematory or other placa) March 8, Date 999 20c. Location - City or Town, Stete 20a. Mathod of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Robert E. Evans Funeral Home, Inc. sun 16000 Annapolis Rd. Bowie Maryland 20715 23a. Purt I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, stock or heart failure. As st only one cause on each line. Approximate Interval Between Onset and Deeth Preumonia and dehydration

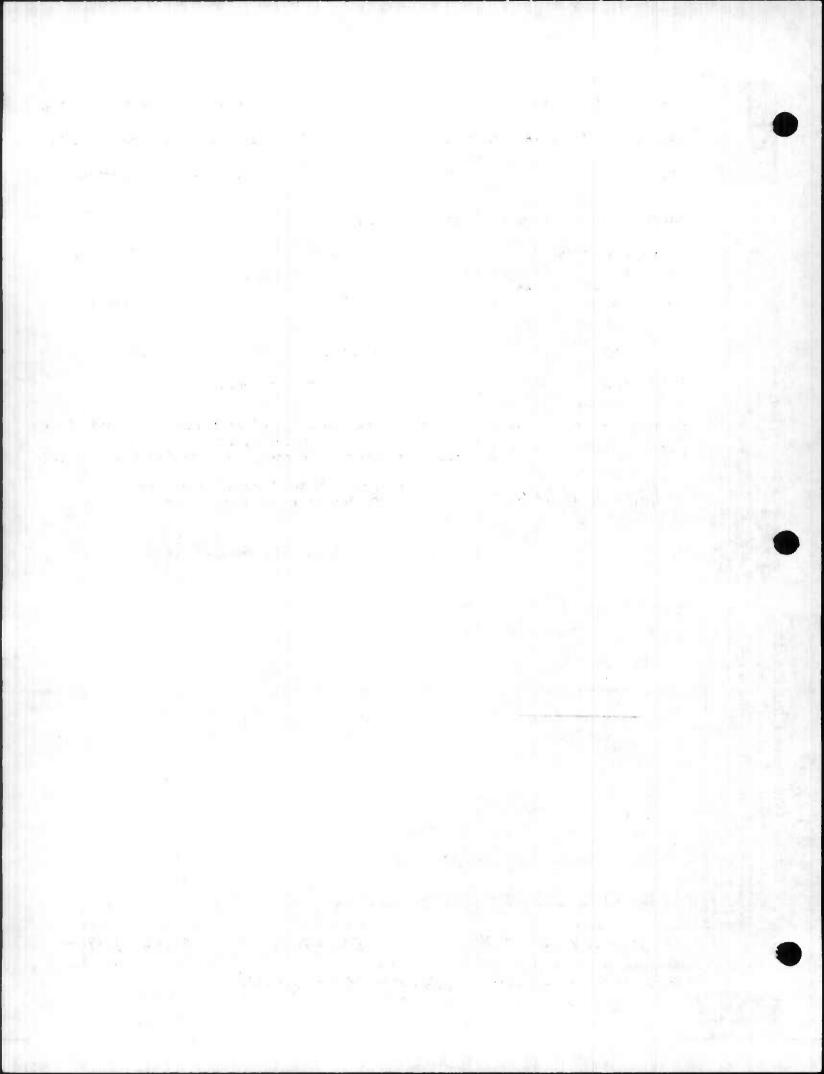
Dua to (or as a consequence of):

Chronic obstructive airway desire

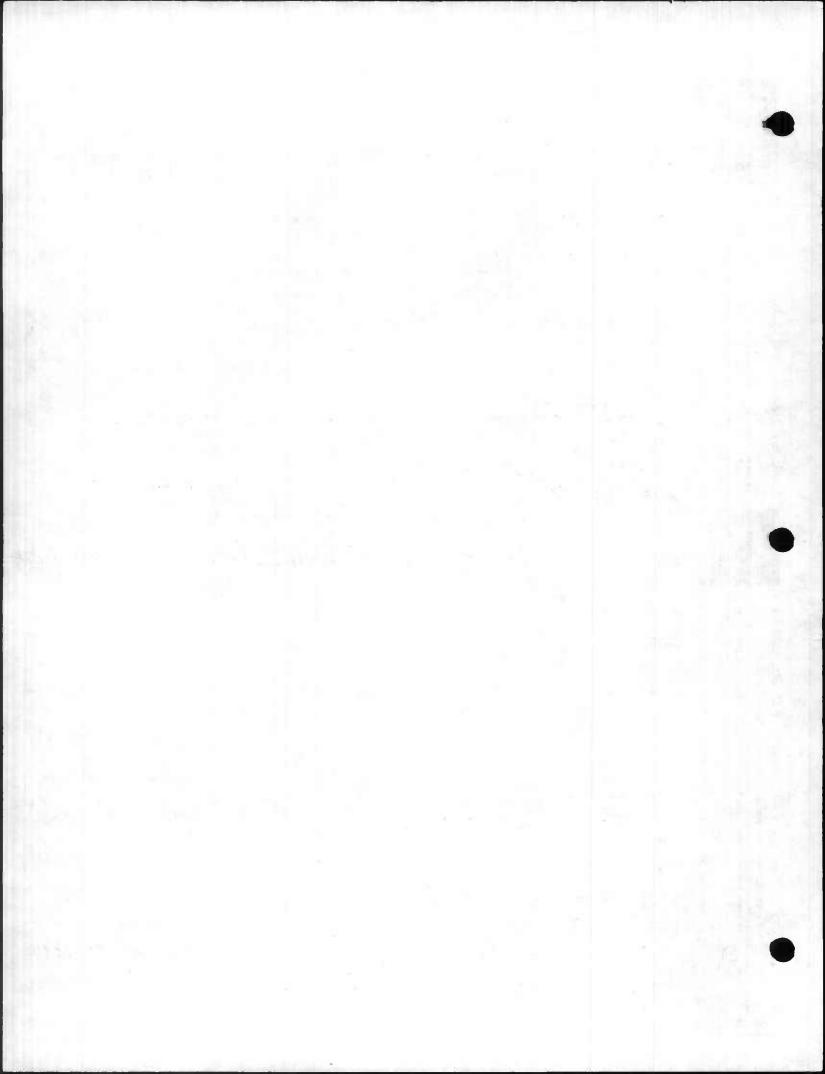
Dua to (or as a consequence of): **Physician** /Medical Immediate Causa (Final disease or condition resulting in death) **Examiner** Sequantially list conditions, if any, leading to immediata cause. Enler Underlying Cause (Disaase or injury that initiated events resulting in death) Last dementia P.O. Box 68760, 20 Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably Unknown Division of Vital Records, by Completed 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Wes an autopsy performed? certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 28. Placa of Daath (Chack only one) 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigetion 1 ☐ Yes 2 ☐ No after death Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 - Homicida To the Hospital within 24 hours a To the Funeral D completely filled Certifying Physician: To the best of my knowledge, dasth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steled. Medical 29a. Cartifiar 29b. Signature end title of certifier

Suzy Club, Prop 29c. License number 29d. Date signed (Month, Dey, Year) 150870 march - 4-99 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) 1221 mercantile In. Upper martiono 31. Data filed (Month) MAR 1 8 1999 32. Registrar's Signatura State Registrar



JOHANNA 4a Facility Name (If not institution, give stre JEWISH CONVALESCEN 5. Social Security Number 214-26-7703	NT CENTER	L	EVY	4b. City, Town, or		12, 1999		9:30 H	
5. Social Security Number 214-26-7703 6. Sex 1	7. Age (In yrs.					46. County	of Death		
214-26-7703 1				BALTIM	ORE		TIMOR	E	
10a. Stata 10b. County		last birthday) Yrs.	If Under 1 Yeer Months Days			, Year) 5, 1913		ca (State or Fore RYLAND	
MD BALTIMOR	10c. City	y, Town or Loc	ation			10d. Inside City Limi			
	RE B	ALTIMOR	E					1 ☐ Yas 2 ☐	
10e. Street and Number			10f. Zip Code			10g. Citizen of V		y?	
7920 SCOTTS LEVE	EL ROAD Was Decedent Evar in U.	C 12 W	21208	Hispania Origina /	Sassifu Vas ar No.		• A •	n Indian	
1XX Never Married 2 Married	Armed Forces? 1 Yas 2 No If Yes, Giva Year or Datas:		Yes, specify Cub		Specify Yas or No- rto Rican, atc.)		k, Whita, et		
15. Decedent's Educati (Specify only highest grade co		16a. Decede	ent's Usual Occu	pation during most of w	orking	16b. Kind of Bu	isiness/Indu	stry	
	College (1-4or 5+)		O NOT use retire MAKER	od)		OWN HO	ME		
17. Father's Nama (First, Middle, Last) MAX	LEVY			18. Mothar's No	ama (First, Middle,	Maiden Sumam		KNOWN	
19a. Informant's Name/Relationship (Type,		19b. Mailing	Addrass (Stree	t and Number or F	iural Route Numbe	r, City or Town,			
MRS. YOLANDA DORSEY/				L AVE. R	T				
20a. Method of Disposition 1 M Burist 2 □ Cremation 3 □ Rem	noval from State		atory or other ple		3/16/99	BALTIM		n, Stete MD •	
4 □ Donation /5 □ Other (Specify) 21. Signature of Funeral Service Moons	BALT		HEBREW (,,				
All Mull XI	Vian I			S	DL LEVINS ROAD PIK				
disease or condition resulting in death) a		or as a consequ		THA C				MMDIM	
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying	500 10 (0	as a consequ	ierice orj.						
Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or	r es e consequ	ence of):				1		
Part II. Other aignificant conditions contrib	buting to death but not rasi	ulting in the un	derlying causa gi	ven in Part I.	23b. Dld t	obacco use cor	ntribute to t	he cause of dea	
					101	res 2□No	3 Probe	ibly 4 ☐ Unkn	
					24a. Wes	en eutopsy med?	evai	a autopsy finding lable prior to pletion of cause eath?	
					101	as 20 No		Yas 2□ No	
25. Was casa refarred to medical axaminer?				26. Pleca of D	aath (Check only o	ne)			
1 Yes 2 1Hosp	1 Inpatient 2	ER/Outpatient	3 DOV		Home 5 Resid				
1 Natural 5 Pending 2 Accident investigation	28a. Deta of Injury (Month, Day Year) 28a. Place of Injury - At ho	28b. Time of Injury		lry at ork?] Yas 2 □ No		Street and Numb		Route Number,	
29a. Certifier 1 (2) Certifying Physicis	building, atc. (Specify	wledge, death	occurred at the ti	ima, data and place	e, and due to the d	cause(s) and me	nner as sta	ted.	
ane)	On the basis of examinet and manner stated.	tion and/or inve							
29b. Signature and title of continue	. /	1.0	29c. Licen	se number		29d. Date signed	d (Month, D	ay, Year)	
30. Name and address of person who compl	plated cause of cleath litem	23a) (Type P	(rint)	114)	MINAC	# /	5,1917	



If Undar 1 Year

Months Deys

4b. City, Town, or Location of Deeth

Min.

8. Data of Birth (Month, Dey, Yaer)

BALTIMORE

If Under 24 Hrs.

Hours

4c. County of Deeth

April 15,1976 Alabama

N/A

Black, White, elc.

White

Birthplace (Stata or Foreign Country)

10d. Inside City Limits 1 Yes 2 No

> Approximata interval Between Onset and Deeth

24b. Were autopsy findings evaileble prior to completion of ceuse of deeth?

1 ☐ Yas 2 ☐ No

29d. Date signed (Month, Dey, Year)

MARCH 16, 1999

JI.G		Please Type or Print in Black Indelible Ink. Assure		
ARRY	LAMB	AMEND ITEMS: #23 PART I, PER MEO G771 5-21-99 WR. ITEMS: #23 PART I, 27 PER MEO G769 3-30-99 WR. Certificate of Death	d Mental Hygiene	3644
		1. Decedent'e Neme (First, Middle, Last)	2. Dete of Death	3. Tima of Deeth
LI .	Physicia	larry Gene Lamb II	MARCH 15, 1999	1154 AM

7. Age (In yrs. lest birthday)

10c. City, Town or Location

22

/Medical **Examiner**

4a Fecility Neme (If not Institution, giva street and number)

10b. County

5. Social Security Number

10e. Stata

219 02 9356

Usuel Rasidence of Decadent

3800 ST. MARGARET STREET

6. Sex

1X M 2□ F

Funeral

Director death with the Merylend r 28a-f show

7 is marked other than "natural", or items 23s or traumatic event, its Medical Examiner must be a Peges 1 and 2 should be filed within 72 hours efter nent of Heelth and Mentel Hygiene. Interfer the marked other than "natural", or flee inty or other traumate event, its Medical Engineer in yor other traumate event, its Medical Engineer. Department of Important: If any Injury or pace.

Maryland 21215-0020

altimore,

/Medical

physician and the buriel-transit that the death certificate be executed Division of Vital Records, P.O. Box 68760, 80 use for signed by the e pege 2 should peen certificate has After this funeral or Attending 6

Physician Examiner efter deeth Director: 24 hours To the Hosp within 24 ho To the Fune completely f

Maryland N/A Baltimore Director 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 3800 St. Margaret Street 21225 U.S. Funeral 12. Was Decedant Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. 1 ☐ Yes 2 No If Yas, Giva Yeer or Detes: 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast greda completed) Elementery/Secondery (0-12) College (1-4or 5+) Worker 9th Fast Food 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Larry Gene Lamb I Nancy Jane White 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Karen Fish / sister 4002 Washington Street Baltimore, Maryland 21227 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Buriel 2 ICremetion 3 ☐ Ramovel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) 3/18/99 Towson, Maryland Hilltop Service Corp. 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimo and polications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and y one ceuse on each line. 4001 Ritchie Highway Baltimore, Md. 21225 MYOCARDITS WITH ABSCESS FORMATION ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Immediate Ceuse (Finel diseese or condition resulting in death) Due to (or es e consequence of): Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury Due to (or es e consequence of): Physician/Medical thet initieted events resulting in death) Lest Due to (or es e consequance of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24a. Was an autopsy Completed Yes 2 No Be 25. Was cese referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 XX Yes 2□ No 28e. Dete of injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending investigation 1 XNaturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end pleca, end due to the cause(s) and menner es steted.

Madical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

State Registrar

29b. Signature and tale of certifie

31. Dete filed (Month, Dev. Year) MAR 18 199

HADUDANTIN BUKORER

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

um?

2. Registrer's Signeture

ARCHO Z

Parties and the second

3 11 1 8AW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

D.K.D		State of Mar	yland / Department of Health and M	lental Hygiene	0.0	201 10
UNKNOWN 99-0	40 LOUIS ALLEN	LUMPKIN	Certificate of Death	Reg. No.	U	3645
1. (Decedant's Name (First, Middla, La			2. Data of Daath Month Day	Yaar	3. Time of Death

/Medical **Examiner**

Directo

Funeral

þ

Completed

Be

12:30 PM

unknown

5. Social Sacurity Number

Baltimore City

Funeral Director

the Maryland r 28a-f show death

ir than "natural", or items 23s or the Medical Examiner nast be r Hygiene. other

filed within 72 hours efter Baltimore, Maryland 21215-0020 other traumatic event, t and 2 should be fi Health and Mentel F tem 27 is marked ot Item 27 permit. Pages 1 Depertment of Hi Important: If ten any Injury or oth phose.

Physician /Medical Examiner Examiner

attending physician and for use as the bunal-transit death certificata be asscuted detached signed t page 2 s certificate hes Physician: funeral director, this After Attending s after death. the filled in by

Physician/Medicai

by

Completed

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Certification:

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Division of Vital Records, P.O. Box 68760,

Louis Allen Lumpkin FEB. 21, 1999 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death BALTIMORE 125 NORTH PATTERSON PARK 7. Age (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) June 17, 1956 Birthplece (Stata or Foraign Country) Days Hours 0€ M 2 F unknown unknown Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Insida City Limits 10b. County unknown unknown 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda unknown U.S.A. unknown 11. Marital Status unknown Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. 1 Naver Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highest grada complated) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elamantary/Sacondary (0-12) Collaga (1-4or 5+) unknown unknown unknown unknown 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) unknown unknown 20b. Place of Disposition (Nama of cemetary, crematory or othar place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 □ Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 🛣 Other (Specify) 1n State 4 ☐ Donation 5 1 Othar (Specify) 21. Signature of Funaral Service Licensea. ²² State Anatomy Board, 655 W. Baltimore Street Director Baltimore, Maryland 21201 Why rt1. Entar tha disaase, or complications that caused tha death. Do not anter the mode of dying, such as cardiac or respiratory arrest, ock, or haert feilure. List only one cause on each line. 23a. P Immediata Causa (Final disaasa or condition rasulting In daath) Narcotic and Alcohol Intoxication Due to (or as a consequence of): Dua to (or as a consequence of) Due to (or as a consequence of): rasulting in daeth) Last 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death?

Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying Cause (Disaasa or injury that initiated avants

1 Yee 2 No 3 Probably 4 WUnknown 24a. Wes an autopsy performed?

26. Placa of Death (Check only ona)

Unknown

24b. Wara autopsy findings available prior to completion of cause of death? 1 Dras 2□ No

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25. Was casa rafarred to medical XX Yas 2 No

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27. Mannar of Death

1 Neturel

2 Accident

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Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Tima of Fournd: 28a. Data of Injury (Month, Day Year) 5 Pending (Month, Day Year) Fourittic investigation Found: 2/21/99 12:30P
6 Double of the Page 1 Could not be determined with Secretary and Secretary Production of the Secretary Page 1 Could not be secretary and secretary productions of the Secretary Page 1 Could not be secretary and secretary productions of the Secretary Page 1 Could not be secretary and secretary productions of the Secretary production of the Secretary page 1 Could not be secretary productions of the Secretary production of the Secretary page 1 Could not be secretary productions of the Secretary production of the Secretary page 1 Could not be secretary productions of the Secretary production of th

28c. Injury at Work? 1 Yas 2 No

Othar: 4 Nursing Homa 5 Rasidance eXXOther (Specify) AT SCENE 28d. Dascribe how Injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) Found in vacant house

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to tha cause(s) end menner es steted.

MD • Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete end plece, end due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie

18

29c. Licansa number O.C.M.E 29d. Data signed (Month, Day, Year) 22, 1999 FEB.

125 N. Patterson Ave., Balto.

30. Name and addrass of person who completed cause of deeth (Item 23a) (Type, Print)

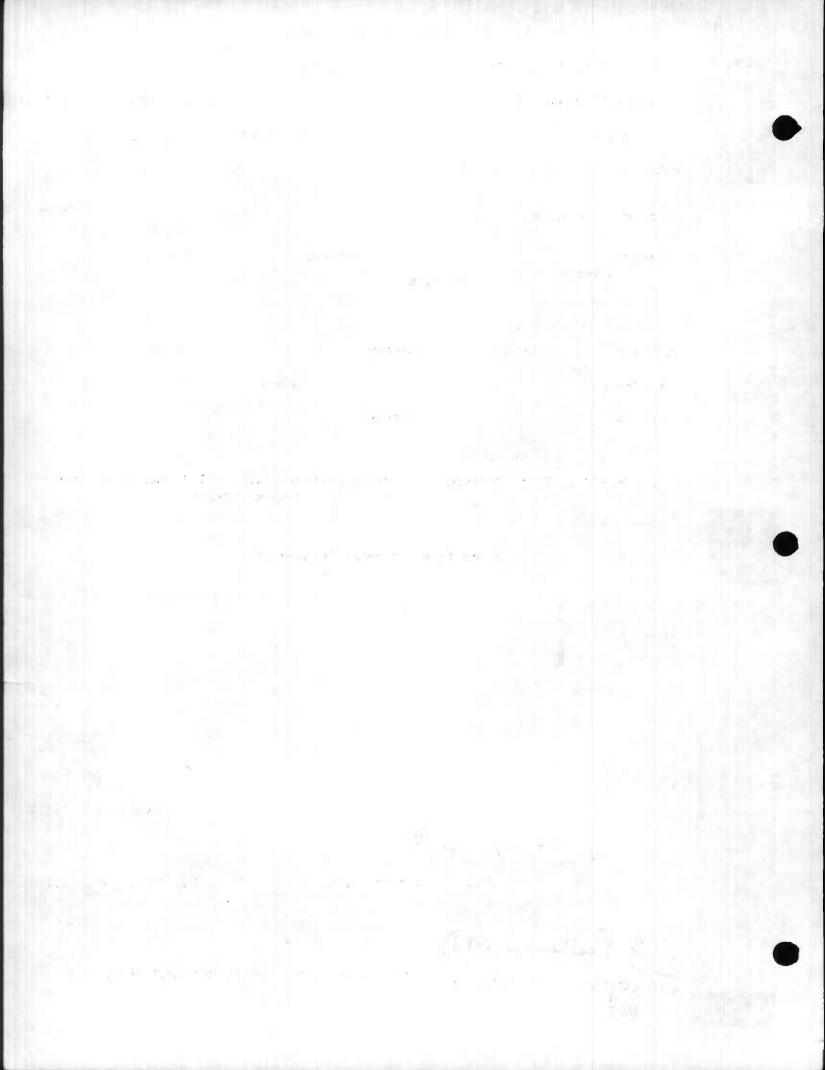
Restance 1111 Penn Street, Baltimore, Maryland 21201 Pestaner

State Registrar

32. Registrar's Signatura were Sparky

Hospital 24 hours

within 2 the



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 8:10 AM George E. Mapes, Jr. March 17, 1999 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Heritage Nursing Center Dundalk Baltimore County If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In vrs. lest birthdev) XX M 2 F Months 219-16-6885 March 5, 1925 Maryland Usual Residence of Deceden 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7232 German Hill Road USA 21222 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'a Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) House Painting Painter 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Irene Bell George Mapes, Sr 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant'a Neme/Reletionship (Type, Print) Niece 604 46th Street Baltimore, Maryland 21224 Linda Thomas 20a. Method of Disposition 20b. Place of Disposition (Neme of cametery, cremetory or other plece) Date 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/18/99 Baltimore, Maryland Baltimore National 21. Signature Funeral Service Licensee 22. Name and Address of Facility Burgee-Henss Funeral Home PA 21211 36.31 Falls Road, Baltimore, Maryland shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death un Obstutul Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Due to (or es e consequenca of): Part if, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 24b. Were autopsy findings evailable prior to 24a. Was an autopsy completion of cause of death? 1 Yes 2 No 1 ☐ Yea 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 3√3 Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homlcide

Division of Vital Records, P.O. Box 68760,

Physician

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Baltimore, Maryland 21215-0020

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Registrar

31. Date filed (Month, Day, Year)

29e. Certifier

(Check only one)

29b. Signature and the of certifier

MAR 1 8 1999



30. Napra and address of person who completed cause of death (Item 23a) (Type, Print)

Excertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as atated.

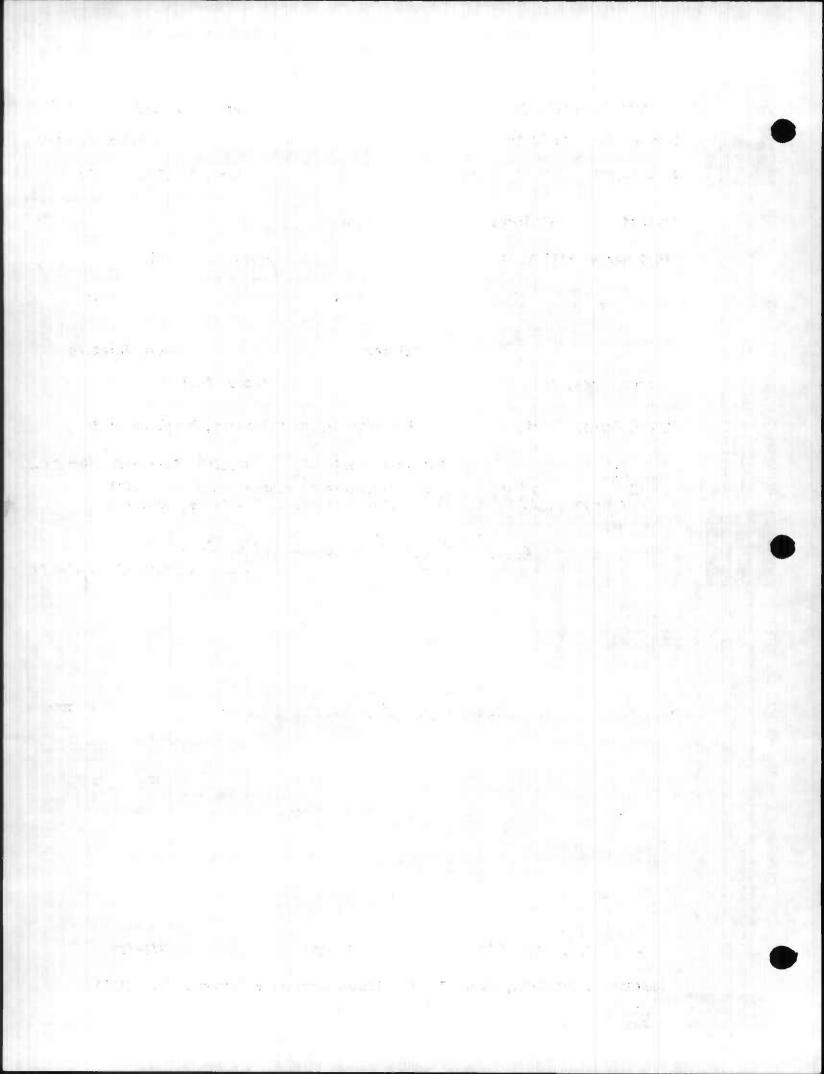
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and piece, and due to the cause(s) and manner stated.

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29c. License number

29d. Date signed (Month, Dey, Year)

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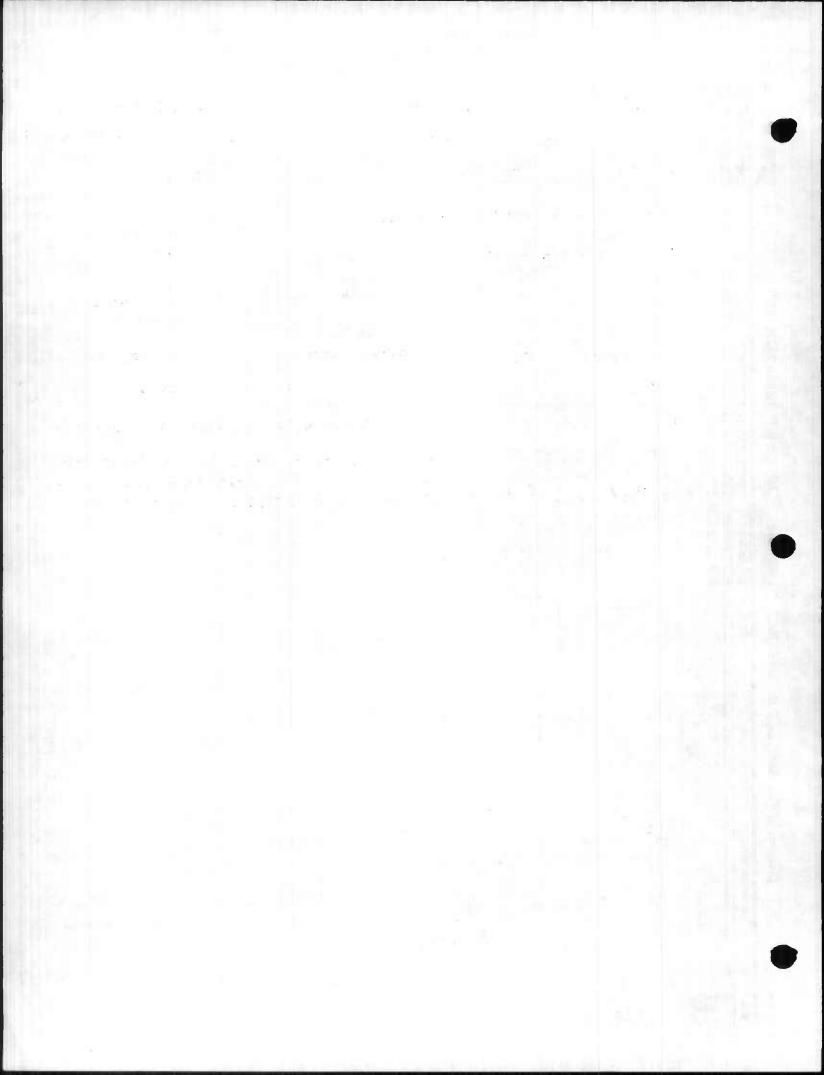


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Physician Gladys McCorkle 1:30 AM March 5 /Medical 4a Fecility Name (If not Institution, giva straat end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Regional Hospital Prince George's Laurel Laure If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Days Hours Min. 1 M 2 T 220-03-1898 Director 02-27-08 NC Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f ehor Prince Georges Beltsvill 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1322 Ingleside Drive 20705 USA Funeral death 12. Was Decedant Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Yaar or Datas: 1 Naver Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "n any injury or other traumatic event, the Med pings. Elementary/Secondery (0-12) College (1-4or 5+) Salad Maker 10th Grade Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surneme) Wiley Best Lillie Moyes 20743 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) Ethel 6316 Morocco Street Capital Heights, MD. Lineberger 20b. Place of Disposition (Neme of cametery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 03-19-99 Woodlawn, MD 21. Signature of Funeral Servica Licensee 22. Name and Addrass of Facility Baltimore, Maryland 21202 du WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 17dey Examiner Due to (or as a consequenca of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Physician/Medical the Due to (or as a consequence of) 950 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? 1 Yes 2 No 3 Probably 4 Onknown Conditivas culon Disease Division of Vital Records, þ 9 24b. Wera autopsy findings available prior to completion of causa of death? Completed 24a. Was en autopsy performad? has 1 ☐ Yes 2 1No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 2 12 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1-BNatural 5 Pending investigation death. 1 TYes 2 TNo after death 2 Accident 6 Could not ba determined 3 Sulcida 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Mospital 24 hours a Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner es stated. cal 29a. Certifie (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. To the To the F 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Ave #T-1- Laurel, MD 20707 BHOJRAJ. M.D. 704 Gorman

State Registrar 31. Date filed (Month, Dey, Yeer)

MAR 1 8 1999

32. Registrar's Signatura



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that the death certificate be executed law requires The Division of Vital or Attending Physician: To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At completely filled in by the fu

> State Registrar

Physician

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(Check only one)

29b. Signature and title of certifier

Dr. Miltenberger,

29a. Certifier

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted.

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Johnson Heights Medical Building Cumberland, MD

License number

29d. Date signed (Month, Dev. Year)

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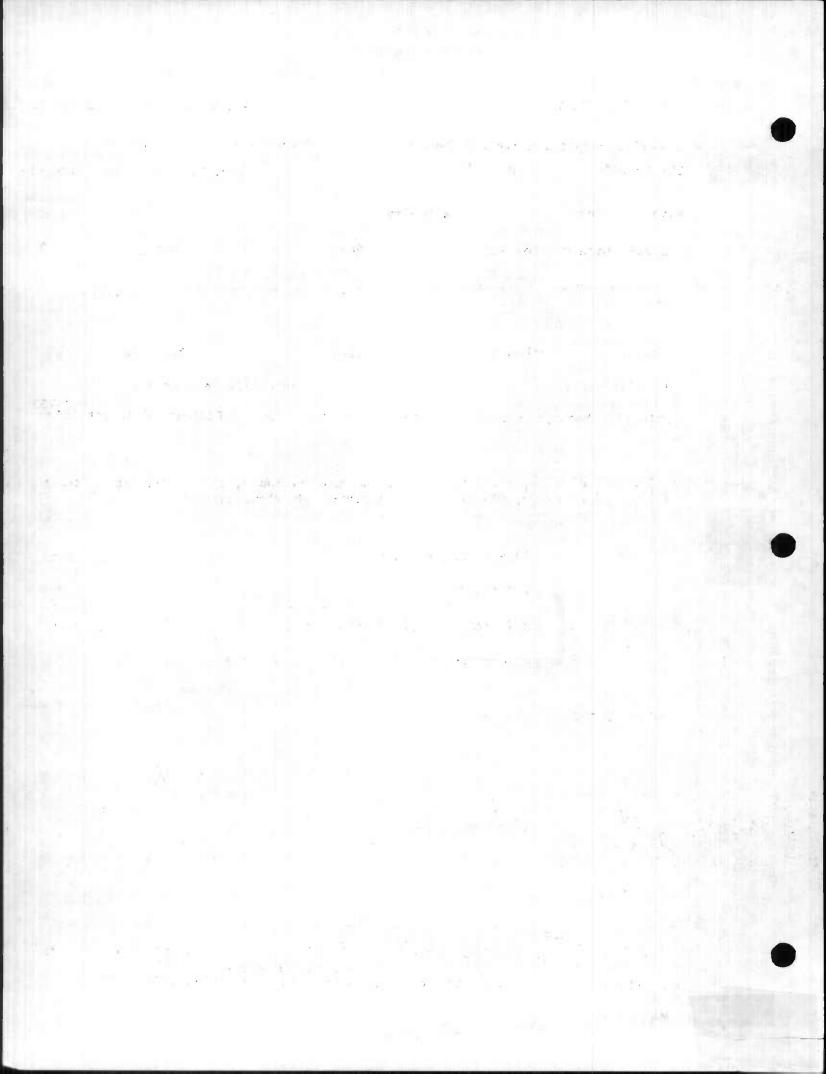
March

Suite 202

1999

1. Sparks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 625 Kent Avenue,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** McKenzie Baby Gir re or uary /Medical 4b City, Town, or Location of Death 4a Facility Nama (If not institution, 4c. County of Death giva street and number) **Examiner** Hospita altimore okins onns HO If Undar 1 Yaar If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 8. Data of Birth (Month, Day, **Funeral** Months Days 1 M 2 DE NONE **Director** Usuai Rasidence of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f shot traumstic event, the Medical Expresser must be included as 1 Tyes 2 No Director 10e. Street and Number 10g. Citizan of What Country? 42300 3 20650 14. Race - Amaricen Indian, Black, White, atc. Funeral permit. Peges 1 and 2 should be filed within 72 hours after death N Depentment of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23. any Inlury or other traumatic event. . Was Decedant Evar in U,S. Armed Forces? 1 Yas 2 No If Yas, Giv Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11. Marital Status Navar Marriad 2 ☐ Married 1 Yas 2 No Spacify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Sacondary (0-12) Collage (1-4or 5+) INFAN7 17. Fathar's Nama (First, Middle, Last) Mother's Neme (First, Middle, Maiden Surnama) 1//10 Unknown 19a. tnforment's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or 656 20b. Place of Disposition (Na cematary, cramatory or 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burlai 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 Othar (Specify) Hospital 21. Signatura of Funaral Sarvice Lines any in 9+. Lfe 23a. Part1. Enter the disease, or combigations that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only are ceuse on each line. Approximata Interval Between Onsat and Death **Physician** Immediate Cause (Final disaasa or condition resulting In daath) /Medical 2 hours Preumothorax Examiner Dua to (or as a consaquance of): Physician/Medical Examiner Distress 6 hours Respiratory physician and s the buriel-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata ceusa. Enter Undarlying Cause (Disaase or injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of) Prematurity 6 hours Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): ed by the a Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by t d be detech 1□ Yes 2 No 3 Probably 4 Unknown Meconium peritonitis þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed peen : Multiple Congenital anomalies (two vessel cord s certificate has b arthograposis) 1 ☐ Yas 2 X No 1 X Yas or Attending Physician: 25. Wes cesa rafarred to medical axaminar? 26. Placa of Death (Check only one 1 ☐ Yas 2 No Other: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify) Certification: To 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA this After this funeral d 28a. Data of Injury (Month, Day Year) 28c. tnjury at Work? 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred 1 Naturai 5 Pending 1 ☐ Yas 2 ☐ No death. invastigation 2 Accidant Funeral Director: 6 Could not be datarmined 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred et tha tima, data and piace, and dua to the ceuse(s) end manner es steted.

2 Medical Examiner: On the basis of axaminetion end/or invastigation, in my opinion, daath occurred at tha time, dete end place, end dua to the causa(s) and manner statad. 29a. Certifian (Check only one)

State Registrar

MAR 1 8 1999

29b. Signatura and title of certifier

31. Date filed (Month, Day, Yaar)



Gustopler Helden MD

30. Nama and addrass of person who complated causa of daeth (Itam 23a) (Type, Print)

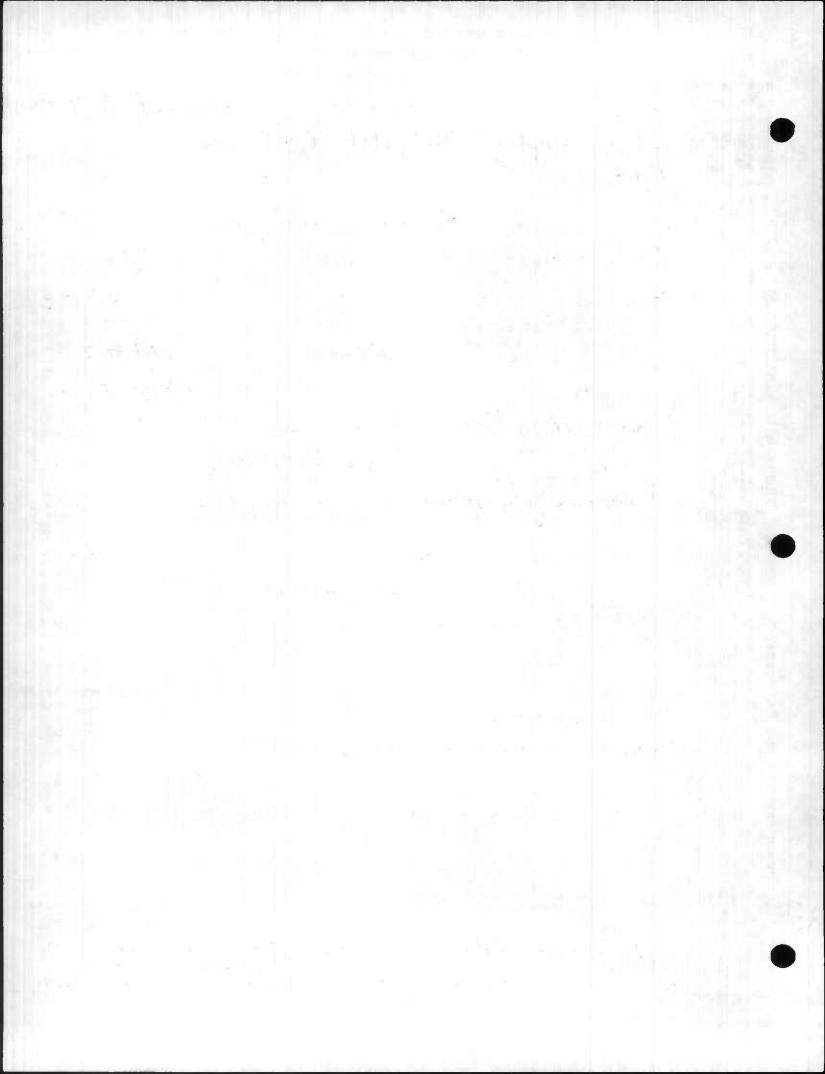
Johns Hopkins Hospital, Baltimore, Maryland 21287

29c. Licansa number

KES-000

29d. Data signed (Month, Day, Year)

600 North Wolfe Street



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Sanuary 37, 1999 MELSON ISAIAH MALIQUE 4b, City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Baltimore Hookins Hospital Johns If Undar 24 Hrs. 6. Sex 10 M 20 F If Under 1 Year Months Days 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 9. Birthplaca (State or Foreign Hours UNKNOWN 25 Usual Rasidance of Decedant 10a. Stata 10c. City. Town or Location 10b. County 10d. Insida City Limits 1 Yas 2 No 10e. Street and Number 10f Zin Coda 10g. Citizan of What Country? 39209 13. Was Decedent of Hispanic Origin? (Specify Yas or Noff Yas, specify Cuban, Maxican, Puarto Rican, atc.) 9 5460 rive 12. Was Decedent Evar in U,S. Armed Forces? 1 Yas 2 No If Yas, Giva 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. 1 Navar Married 2 Married 1 Yas 2 No Specify: /ac/C 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Spacify only highast grade complated) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) INFANT INFANT 0 18 Mother's Neme (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Unknown Kadlence 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Steta, Zip Coda) 19a. Informant's Nama/Relationship (Type, Print) (mother) 546 CHADVIEW Ksonville 20b. Place of Disposition (Nama of 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Grametion 3 DRamoval from Stata Donastopkins Hospita 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral 22. Nama and Addrass of Facility N. WDLfe 600 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata interval Between Onsat and Death Immediata Causa (Final disaasa or condition resulting in deeth) 2 days Due to (or as a consequence of): da pulmonary Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Wara autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performad? 2 No 1 ☐ Yes 2 X No 26. Placa of Daath (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify)

Physician /Medical Examiner

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Division of Vital Records, P.O. Box 68760,

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Baltimore, Maryland 21215-0020

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25. Was casa rafarred to madical axaminar? 1 Yes 2 No 27 Manner of Death

1 Natural 2 Accident 5 Pending Invastigation 6 Could not be dataminad 3 Suicida 4 Homicide

Hospital: 1 Inpatiant 2 ER/Outpatiant 3 DOA 28a. Date of Injury (Month, Dey Year)

28b. Time of Injury

28c. Injury et Work?

1 Yas 2 No 28a. Place of Injury - At homa, farm, straet, factory, office building, atc. (Specify)

28d. Dascribe how injury occurred 28f. Location (Straat and Number or Rural Route Number, City or Town, Stete)

29a. Cartifian (Check only one)

1 Certifying Phyelcian: To the bast of my knowledge, death occurred at the time, date and place, and due to the causa(s) end menner es stated.

2 Medical Examiner: On the basts of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

29b. Signatura and titla of certifia

Pediatric Resident cour MD

29c. Licensa numbar RES-000 29d. Data signed (Month, Day, Year)

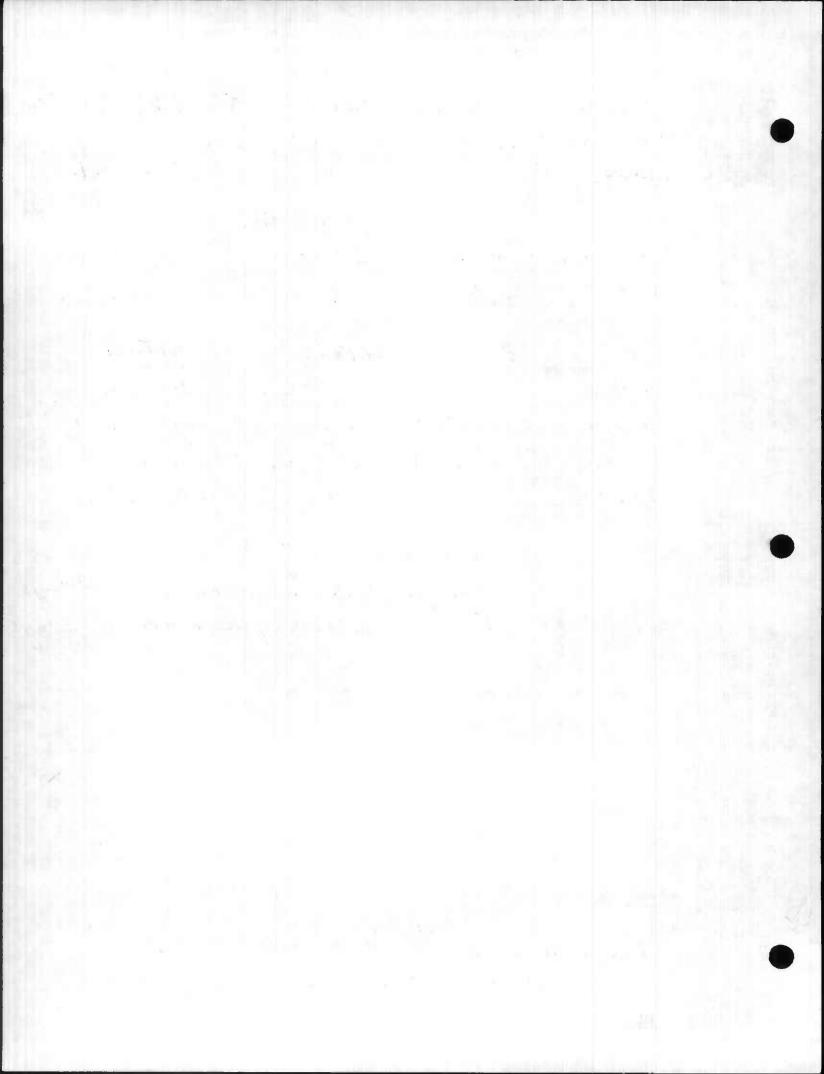
30. Nama and address of person who complated causa of daath (Itam 23a) (Type, Print)

N. Wolfest-Bathmore Md 400 CHOUKAIR 31. Date filed (Month, Dey, Year)

State Registrar

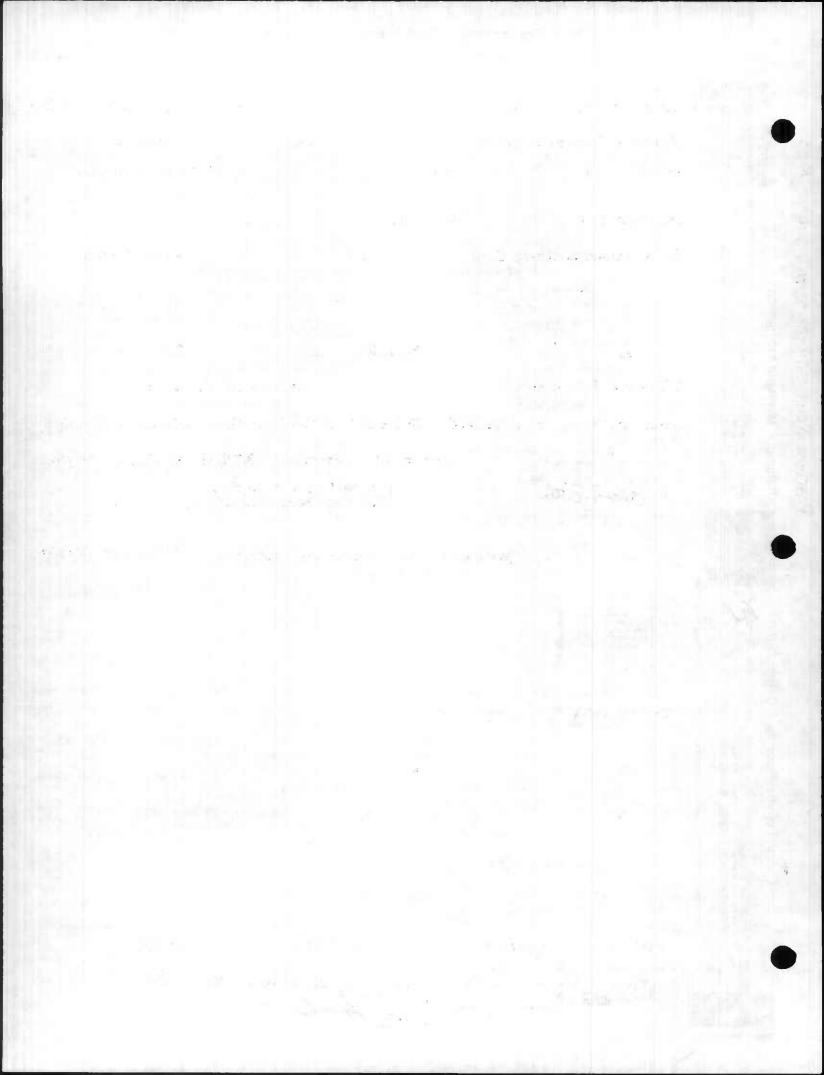
MAR 1 8 1999

32. Registrar's Signatura



							Ce	rtifica	te of	Death		R	eg. No. 💅	1 3	UE	001
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DHMH 16 Rev 6/95



Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 9 6 5 2

1. Deced	ent's Name (First, Middle,	Last)		Cert			2. Dete of I			3. Time of Death	
ician	TRICIA		M	CINT	YRE		Month	Day 14	Yeer 1999	20:15	
	y Name (If not institution,	give street end numbe		1.1		4b. City, Tow	n, or Location of De		y of Death		
Th	e John	s Honk	cins	ttos	pita	1 1091-	Timore	N	I/A		
al 5. Social	Security Number 6			lest birthday)	If Under 1 Months	Year If Under 2 Days Hours	4 Hrs. 8. Date of E		9. Birthple	eca (Stete or Foreign	
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	sidenca of Decedent								Τ		
10e. State	e 10b. County		10c. City	y, Town or Loc	ation				10	Od. tnside City Limits	
8 Mary	rland N/A		Ba	altimor	e					11X Yes 2□ No	
10e. Stre	et end Number				10f. Zip (Code		10g. Citizen of		try?	
562	3 Gardenvill	e Avenue				21206		U.	S.A.		
11. Marita	al Status	12. Was Decede Armed Force	nt Ever in U,	,S. 13. W	as Decede	nt of Hispanic Orlg	n? (Specify Yes or I Puerto Rican, etc.)	No- 14. Ra	ca - America	American Indien,	
I IXN	1 XNever Married 2 ☐ Married		Ď No		☐ Yes 2			Speci			
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ete	15. Decedent's I (Specify only highest g	Education			Decedent's Usual Occupation (Give kind of work done during most of wo			16b. Kind of I	of Business/Industry		
Maryland N/A 10e. Street end Number 5623 Gardenville 11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorcad 15. Decedent's I (Specify only highest g Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last	College (1-4c	College (1-4or 5+)		life. DO NOT use retired)							
	5+ yea	ars	Medi	cal 1	Doctor		Medi				
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e C1	yde	McInt	tyre			Irma		Ahler			
	ment's Name/Relationship	(Type, Print)		19b. Meiling	Address	Street end Number	or Rural Route Nur	nber, City or Town	n, Stete, Zip	Code)	
Mary	Ross (pers	onal Rep.					enue Bal	timore,	Maryl:	and 21206	
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21. Signa				Mi	itche.	ll-Wiedef	eld Home,	Inc.			
220 Per	erre!	4011		/ -					1 0		
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32. Registrar's Signature

State Registrar

There is a process of the part STATES LABORITHESING TO CATE OF the property of the they were THE REST CONTRACTOR AND ADDRESS OF THE PARTY Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 5:45AM RHODA MENDELSON MARCH 16 1999 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner STELLA MARIS HOSPICE TIMONIUM BALTIMORE If Under 1 Yaar Months Deys If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth JUNE 22 1911 9. Birtholace (State or Foreign **Funeral** Months Hours 1 M XX F MINNESOTA 87 149-28-5925 Director Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location TEANECK 10d. inside City Limits 28a-f show Examiner must be notified at ŇJ. BERGEN Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 863 RED ROAD 07666 U.S.A. "natural", or Itama 23a Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Reca - American Indian, 11 Marital Status Was Decedent Evar in U,S. Armed Forcas? Black, White, etc. filed within 72 hours after Yes 2V No 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 € No Specify: Specify:WHITE p 3X Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry ith end Mental Hygiene.
27 is merked other than "r traumatic event, me Med Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Pages 1 end 2 should be nent of Heelth end Mental HIRSCH LEWIS CHAZIN DORA MARGOLIS 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) If hem 27 or other tr LILLIAN FAFFER/DAUGHTER 310 E. 70TH STREET APT. 1-E NYC. NY. 10021 20e. Method of Disposition

1 □ Burlel 2 □ Cremation 3 ☑ Removel from State 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete SHAAREY TEFILOH CEMETERY 3/17/99 PERTH AMBOY NJ. Department of Important: If any injury or pace. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility SOL LEVINSON & BROS. INC. 21. Signature of Funara Sa 8900 REISTERSTOWN ROAD PIKESVILLE MD. 21208 23a. Part1. Enter the diseasa, or complications that caused the deeth. Do not enter the moda of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical immediata Causa (Final diseese or condition resulting in deeth) Examiner Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated evants resulting in death) Last Due to (or es e consequença of) physician s the burial Box 68760 Physician/Medical Due to (or es a consequenca of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? signed by the 3 Probably Unknown 1 Yes 2 No Division of Vital Records. à 24b. Ware eutopsy findings available prior to completion of cause of deeth? Completed should 24a. Wes en eutopsy performed? 1 Yes 210/No certificate 1 Tas 25. Wes case referred to midical exeminer? Be 26. Placa of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28e. Dete of Injury (Month, Dey Year) funeral 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Hospital or Attending atural Accident death. 1 Tyes 2 No within 24 hours after deal To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier completaly \$ 29b. Signeture and the of certifier 29d. Daty signed (Month, Day, Year) Middress of person who completed cause of death (Item 25e) (Type, Print) M

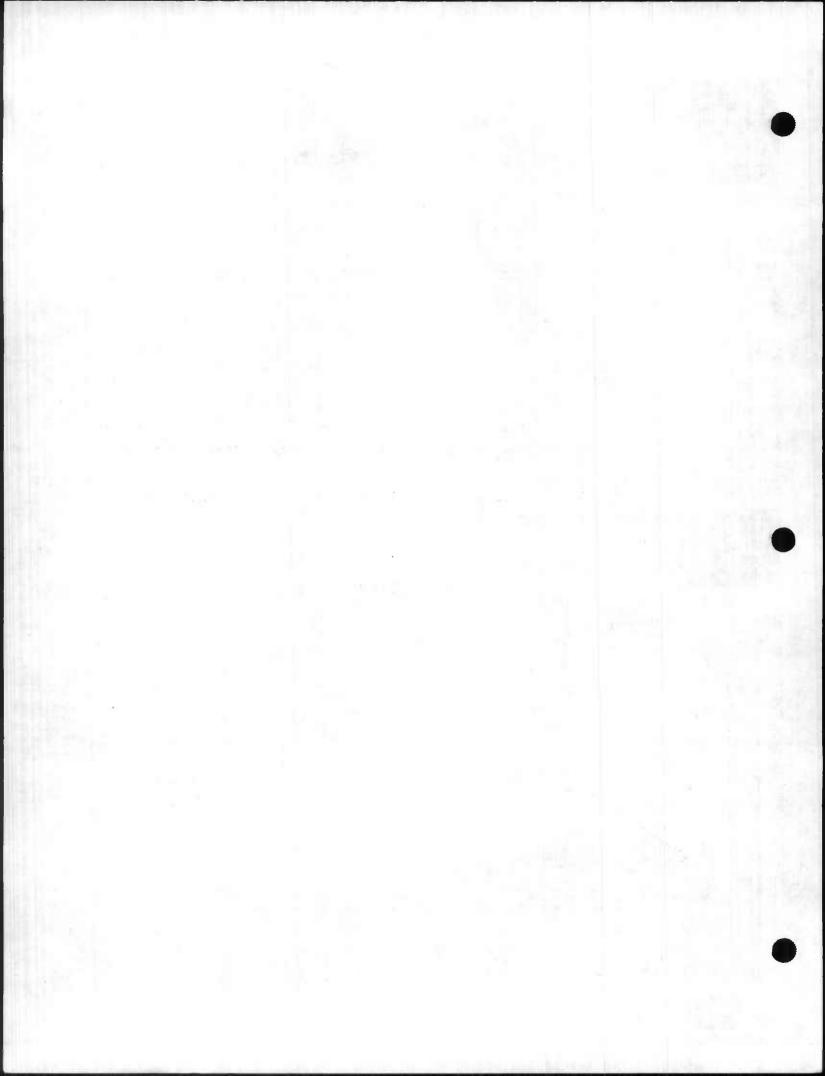
State Registrar

31. Dete filed (Month, Dey, Year)

MAR 18

DHMH 16 Rev 6/95

32. Registrar's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death **Physician** :00 PM MARCH JOHN MOSSMAN /Medical 4c. County of Deeth 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner BALTIMORE HARBOR CENTER HOSPITAL N/A If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Deta of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 120 M 2□ F Yrs. 217 78 2617 39 June 8, Director Maryland Usual Residence of Decedent 10a, Steta 10b. County 10c. City, Town or Location 10d. fnside City Limits ahos 12 Yes 2 No Maryland Directo N/A 28a-f Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 'natural', or flams 23s or 1323 Church Street 21226 U.S. Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) Was Decedent Evar in U,S. Armed Forcas? 14. Race - American Indian, 11. Marital Status Bleck, White, etc. 1 ☐ Yes 212 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried altimore. Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: à White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Meat Packer 10th Save A Lot Grocery permit. Pages 1 and 2 should be fits.
Department of Health and Mental Hy, important; if Nem 27 is marked other any Injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Virgil Mossman Evelyn Poland 19a. tnforment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Evelyn Mossman / mother 4902 Pennington Avenue Baltimore, Maryland 21226 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 🖾 Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 3/15/99 Hilltop Service Corp. Towson, Maryland 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Gonce Funeral Home P.A. ecome mamuowsku 4001 Ritchie Highway Baltimore, Md. 21225 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** CELL NEURO EPIDERMAL /Medical tmmediete Ceuse (Final diseese or condition resulting in death) TUMOR 7 MONTHS Examiner Due to (or es a consequence of): Examiner physician and s the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequenca of): Box 68760, Physician/Medical Due to (or es e consequenca of) 080 ō 23b. Dtd tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown b 24b. Were eutopsy findings aveilable prior to completion of causa of death? 24e. Wes en eutopsy performed? Completed certificate To the Hospital or Attending Physiolan: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) P 2 ER/Outpatient 3 DOA 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. tnjury et Work? edical Certification: 5 Pending invastigation 1 Neturat 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be

Records, P.O. Division of Vital

DHMH 16 Rev 6/95

State Registrar

SAMEER BADE, MD 31. Dete filed (Month, Day, Year)

MEDICAL RESIDENT

29d. Date signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARBOR HOSPITAL 32. Registrer's Signeture

28e. Plece of fnjury - At home, ferm, street, fectory, office building, etc. (Specify)

3001 SOUTH HANOVER ST, BALT, MD 21225

MAR 1 8 1999

3 ☐ Suicida

29a. Certifier

4 Homicide

(Check only one)

29b. Signeture and title of certifier

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner stated.

29c. License number

ME AND LANGUAGE BUILDING

Physician /Medical Examiner

that the death certificate be assouted

The law requires

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deeth.

Hospital or To the Hospital of within 24 hours of To the Funeral Dicompletely filled in

after deet Director:

6

Medical

Box 68760

Records, P.O.

Division of Vital

Physician

/Medical

Examiner

Funeral

Director

Ahow

"natural", or frame 23s or 28s-f show

filed within 72 hours after of Hygiene.

Peges 1 and 2 should be filed value of Health and Mentel Hygie int: If Item 27 is marked other I

nt of Health a: If ham 27 is or other tre

permit. Pege Department o Important: If eny injury or pace.

Baitimore, Maryland 21215-0020

Director

Funeral

P

Completed

the Maryland

Examine attending physician and for use as the burial-transit Physician/Medical signed by the a pege 2 s Be

þ Completed To Certification:

25. Was case referred to medical axaminer?

Natural 2 Accident investigation 6 Could not be determined 3 Suicide 4 Homicide

peur

MAR 18

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steled.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steled.

29a. Certifier (Check only one) 29b. Signature and tifle of certifier

29c. License number

Calculono , mos

29d. Date signed (Month, Day, Year)

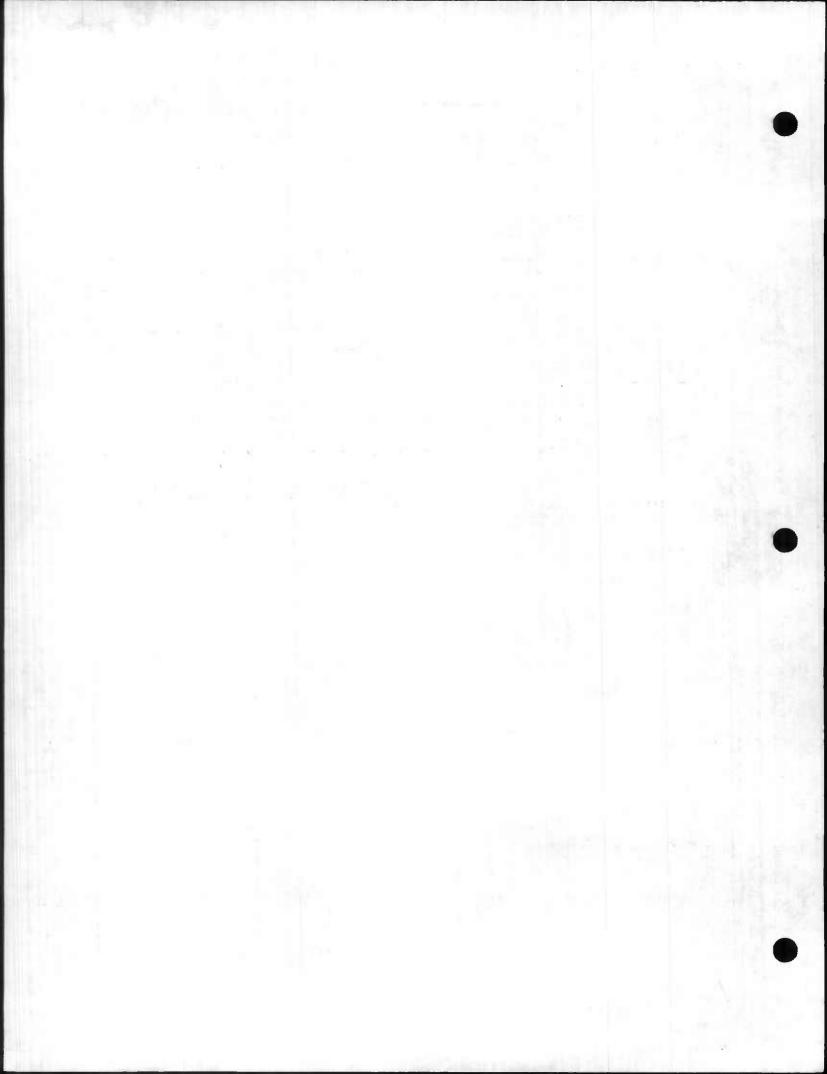
Name and address of person who completed cause of death (Item 23a) (Type, Print) 11015 HTTLE

31. Date filed (Month, Day, Year)

32. Régistrer's Signeture

Parried

State Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2. Data of Death 1. Decedant's Nama (First, Middla, Last) 3. Tima of Death **Physician** Lawrence Lee Morton, Sr. 14, 1999 MARCH 12:55 PM /Medical 4c. County of Death 4a Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Saint Agnes Hospital Baltimore n/a If Undar 24 Hrs. Hours Min. If Undar 1 Year 5. Sociel Security Number Birthplaca (Stata or Foraign Country) 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) **Funeral** Days 1₩ 2□ F 91 215-24-2205 Yrs Director June 21, Md. Usual Rasidanca of Dacedant with the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside Ctty Limits tem 27 is marked other than "natural", or fems 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at Md. n/a Baltimore Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 1633 N. Hilton Street USA Funeral deeth 14. Race - Amarican Indien, Bleck, White, etc. 12. Was Dacedent Ever in U,S. Armad Forcas? Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 1 and 2 should be filed within 72 hours after 1 Yas 2 No If Yas, Giva Year or Datas: 1 Navar Married 2 Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: Black Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grada complated) Lawrence Morton pernit. Peges 1 end 2 should be filed within Department of Haalth and Mental Hygiene. Important: If item 27 is marked other than " Elementery/Secondary (0-12) Collaga (1-4or 5+) Express, Inc. 12th Grade Businessman 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Meidan Sumeme) William Lee Morton Lucy Wade 19e. Informant's Name/Raletionship (Type, Print) wife 19b. Mailing Addrass (Streat end Number or Rurel Routa Number, City or Town, Stata, Zip Code) Theresa C. Morton 1633 N. Hilton Street Baltimore, Md. 21216 20b. Ptace of Disposition (Name of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Burial 2 Cramation 3 Removal from Stata 4 Donation 5 Other (Specify) 6 March 20 Brooklyn, Md. Mt. Calvary Cemetery any injury 22. Nama and Addrass of Fecility Nutter Funeral Homes, Inc. 21. Signa de a Hunaral Sarvica Licensaa 2501 Gwynns Falls PKWY Baltimore, Md. disaasa, or complications that caused the daath. Do not antar the mode of dying, such es cardiac or respiratory arrest, eilure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** /Medical Immediata Causa (Finel yo Cardia disaasa or conditior rasulting In daath) Examiner Due to (or es a consequence of) Examiner diovascula physician end the buriel-transit Sequantially list conditions, if eny, leeding to immadiata causa. Entar Undarlying Ceuse (Disaase or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Physician/Medical Due to (or es e consequence of) use as 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 3 □ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No by 9 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy has paga 2 2 No 1 Yas 2 No 1 Yas certificata 25. Was casa rafarred to medicat axaminar? funeral director, Be 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 2 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA After this 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 27. Mennar of Death 28b. Time of Certification: 28c. Injury at Work? 1 Natural
2 Accidant 5 Panding 1 ☐ Yas 2 ☐ No death. Invastigation Director: 6 Could not be datarminad 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) filled in by or A 4 Homicida To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To tha best of my knowledge, death occurred at the time, dete end placa, and due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, deta and placa, and due to the ceuse(s) and mannar stated. 29a. Cartifier Medical (Check only one) 29b. Signatura and title of certifian 29c. Licensa number 29d. Date signed (Month, Day, Year)

ospital, 600 Coton Ave, Boltinon

State Registrar Theodore

31. Data filad (Month, Day, Year)

30. Neme and eddress of person who completed quite of death (Itam 23a) (Type, Print)

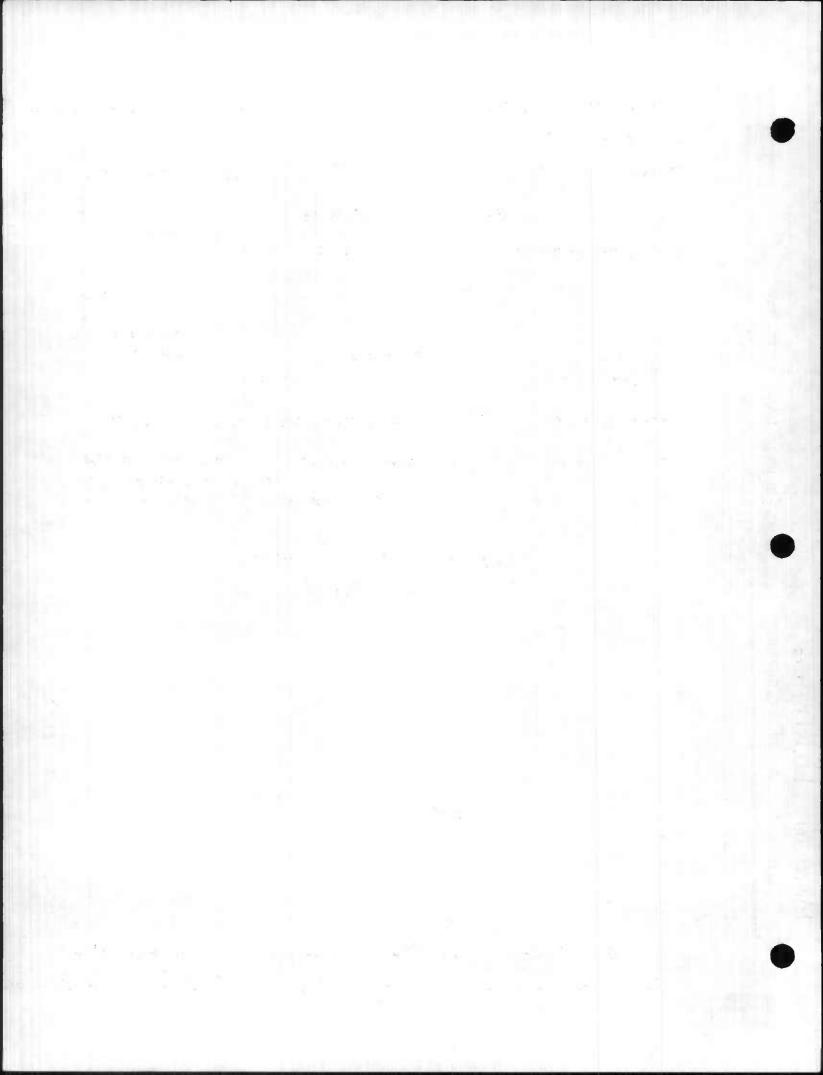
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32. Registrar's Signature

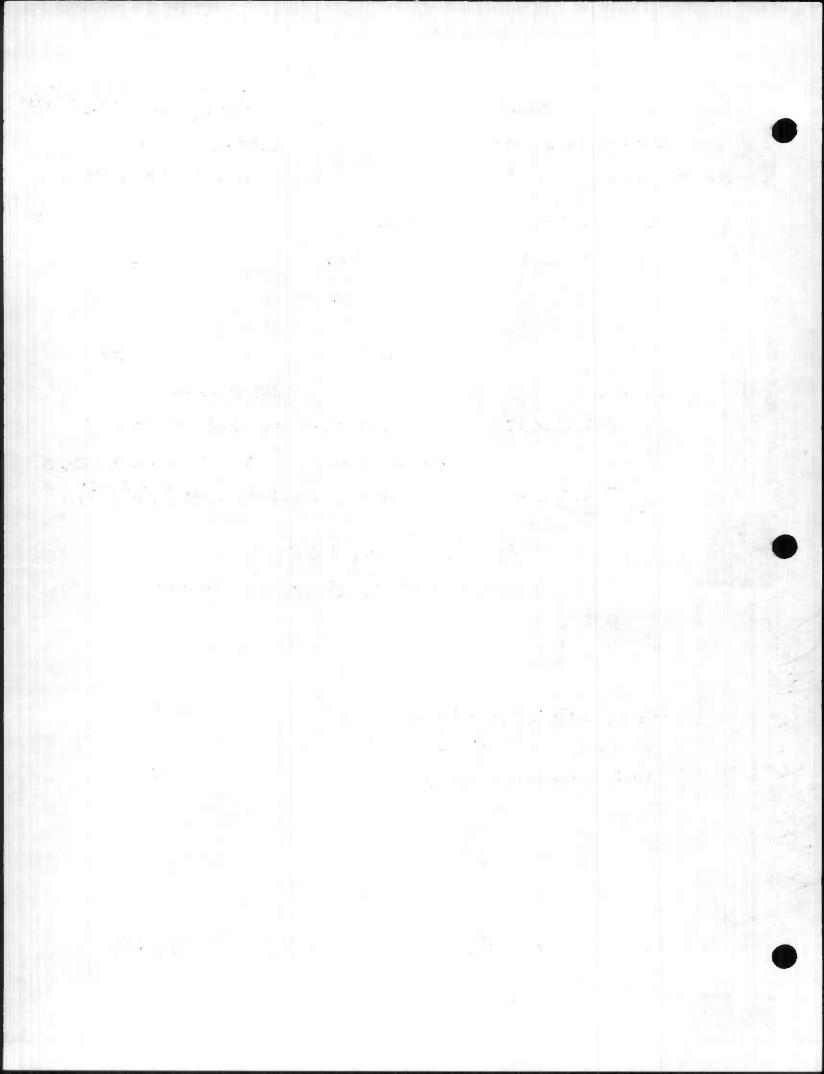
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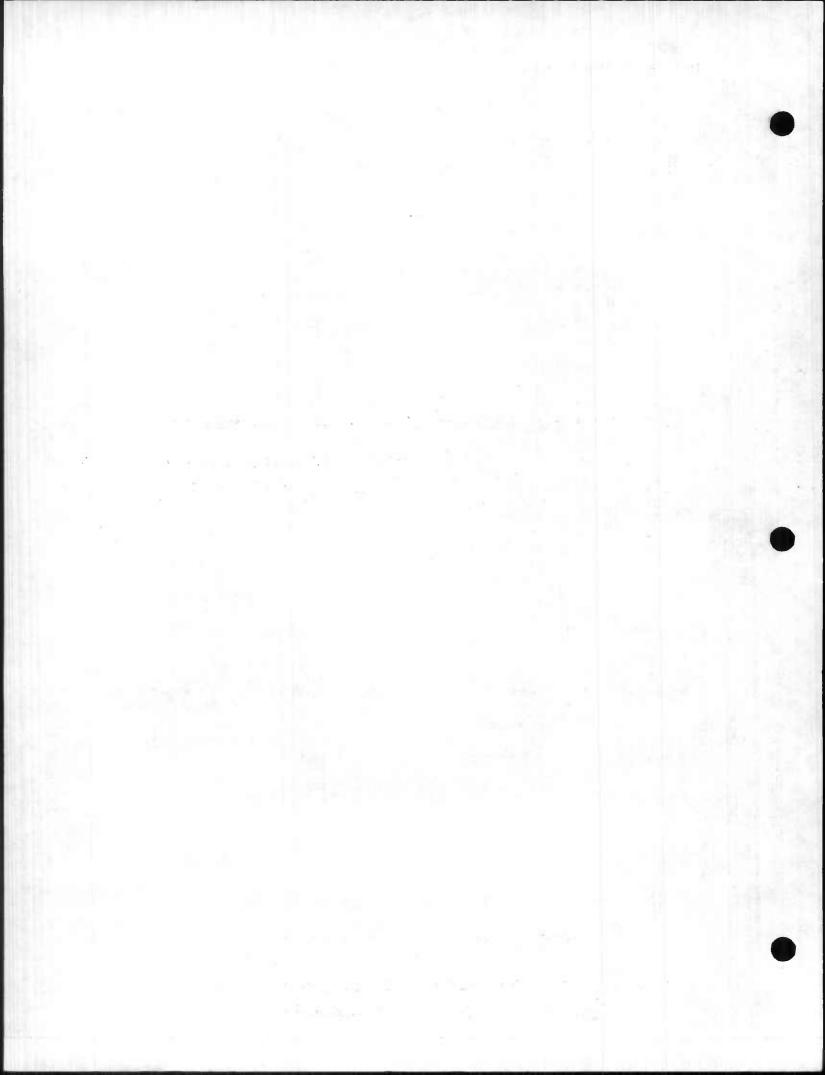
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death

		· · · · · · · · · · · · · · · · · · ·	Certificate of	Death	Reg. No.	08657
Physician	1. Decedent's Name (First, Middle, Last) MARY E. MAR	IZIPT		X427	m dog 1969	91/10Am
/Medical Examiner	MARY E. MAR 4a Facility Name (If not institution, give street			4b. City, Town, or Location of Dea	4c. County of Dea	in the
	LEVINDALE NURSING		1 1/11 1 1 1	BALTIMORE	N/A	
Funeral Director	5. Social Security Number 215 16 6380 Usuat Residence of Decedent	7. Age (In yrs. lest birtho	Months Davs	If Under 24 Hrs. 8. Date of B Hours Min. (Month, D		rthplece (Stete or Foreign country) ARYLAND
arytand show id at	10a. State 10b. County	10c. City, Town o	r Location			10d. Inside City Limits
3 48 2	MD BALTIMORE	ROSE				1 ☐ Yes 2 No
\$ 0.8 O	10e. Street and Number		10f. Zip Code		10g. Citizen of What C	ountry?
Other death villens 23 siner mest	1502 SELING AVE	Vas Decedent Ever in U.S.	21237 13. Was Decedent of F	dispanic Orlgin? (Specify Yes or Nen, Mexicen, Puerto Rican, etc.)	USA 0- 14. Race - Am	erican Indien,
02(m., o	1 Never Married 2 Married	Armed Forces? Yes 2XXVo 1 Yes, Give Year or Dates:	1 Yes, specify Cub		Bleck, Whi	
15-(15-neth n 72 h neth edical	15. Decedent's Education (Specify only highest grade control of the n 16a. Do	ecedent's Usual Occup Give kind of work done	pation during most of working d)	16b. Kind of Business	i/Industry	
21215-0 ed within 72 ho ygienie. ser than "neturn t, the Medical.	Etementery/Secondary (0-12)	College (1-4or 5+)	HOMEMAKER	<i>o</i> ,	OWN HON	Æ.
	17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle		
Maryland 62 should be file th and Mental Hy 7 is marked othe traumelic event	JOHN PHIPPS 19e. Informant's Neme/Relationship (Type, I	Print! 10h 1	failine Address (Street	IRENE CAVANA		Zin Code l
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99 1111	20a. Method of Disposition	20b. Place of D	isposition (Neme of cremetory or other ple	Date	20c. Location - City o	Town, State
timor Pages ment of fant if h	1 ⊠Burial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify)		ON FOREST V		GARRISON F	OREST, MD
Ball Depart Import Import Import Import Import	21. Signature of Funeral Service Licensee		22. Name end Addre	ess of Facility EDALE FUNERAL HO	ME BALTO, M	ESACO AVE ID 21237
1 2 1 2 2 1	23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one complications are complications.	ons that caused the death. Do not ouse on each line.	enter the mode of dyi	ng, such es cardiac or respiratory		Approximate interval Between Onset and Death
Physician /Medical	Immediate Cause (Final	Acute Po	onal F	arlure		
Examiner	disease or condition resulting in death) a	A Due to (or as e cpr	T1000000000000000000000000000000000000			1 week
nine:	b	Afterosclerati	ic Cardi	ovavilar Du	eve	yeous
executed in and hal-transh	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cor	nsequence of):			
68760 frank be physician is the burn	Cause (Disease or injury that initiated events resulting In deeth) Last	Due to (or as e cor	sequence of):			1
10 to 10 to	d			•		
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P.O. at the standard sets of a	Part II. Other significant conditions contribu	Ling to death but not resulting in the	to underlying cause gr	(1	Probably 4 Unknown
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al Records, P.O. Box The law requires that the death certains has been signed by the atlanding page 2 should be detached for use Completed by Physician/M	Direase, S	IP Aorhac	nd mi	24a. Wa per	s an autopsy 24b ormed?	. Were autopsy findings aveilable prior to completion of ceuse of death?
Con Con		cements		1	Yes 20No	1 ☐ Yes 2 ☐ No
St Vitts hysician hysician To Be	25. Wes case referred to medicel examiner?	ital: 1 Higpatient 2 ER/Outp	atient 3 DOA Ott	28. Plece of Deeth (Check only her: 4 Nursing Home 5 Res		anih.)
	27. Manner of Death 2	Ba. Date of Injury (Month, Day Year) 28b. Tim	e of 28c. Inju		how injury occurred	вспу)
Sion Sion Seath to the fundamental seath the fundamental seath the fundamental seath the seath t	1 Naturat 5 Pending 2 Accident investigation 3 Sulcide 6 Could not be		M 1	Yes 2□No		
Division Att	4 Homicide determined 2	Be. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	281. Location City or To	(Street and Number or I own, Stete)	fure! House Number,
Hospita M hours Funeral tely filled IIcal C	(Check only 2 Medical Examiner:	n: To the best of my knowledge, d On the basis of examination and/o and manner stated.	eath occurred at the ti or investigation, in my o	me, date and place, and due to the opinion, death occurred at the time	cause(s) and manner a , date and ptace, and du	is stated. se to the cause(s)
within 2 To the comple	29b. Signeture end fittle of certifier		29c. Licens		29d. Date signed (Mor	nth, Day, Year)
	Scioen M	X4Mo	03	3943	3/12/99	
	30. Name end eddress of person who complete		Pe, Print) Cundali	P		
State	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Colorodo			
Registrar	MAR 1 8 1999	former B.	hosels!			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

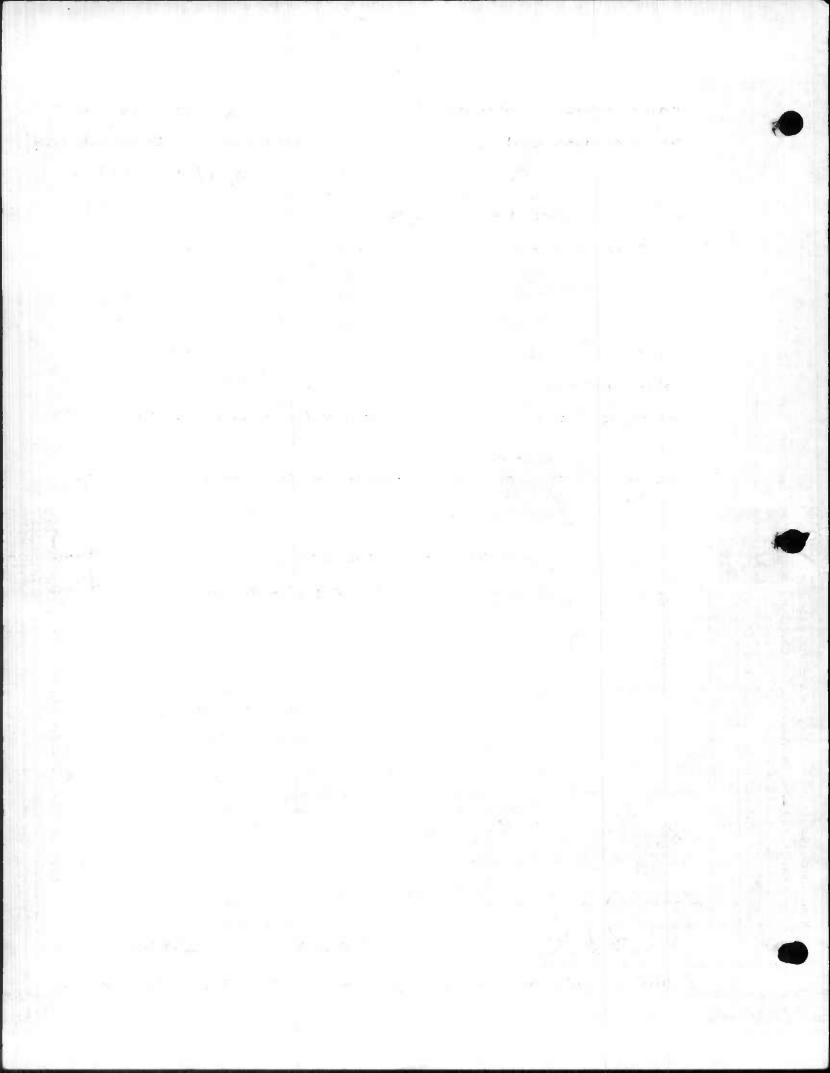
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MARGARET AN		N			2. Date of Dea Month March	Day	Year 1999	3. Time of De 6:40 P
4a Facility Name (If not institution, give :				4b. City, Town, or	Location of Death	4c. County	of Death	
Stella Maris Hos				Timoniu			altimo	
5. Secial Security Number 6. Sex 212-10-8899	7. Age (In yrs. Is M 27 F 96		f Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey	Year)		ice (State or Fo
Usual Residence of Decedent	A 90				June 15	, 1902	Mary	rland
10a. State 10b. County	10c. City	, Town or Locat	ion		100		10	d. Inside City L
Maryland N/A	Ba	altimore	2					Yes 2[
Maryland N/A 10a. Street and Number			10f. Zip Code			Og. Citizen of V	Vhaf Count	y?
				21209			J.S.A.	
1821 Sulgrave At	12. Was Decedent Ever in U,S Armed Forces?		s Decedent of F es, specify Cub	lispanic Origin? (S an, Mexican, Puerl	o Rican, etc.)	Blac	e - Americe k, White, e	tc.
3 ₩ Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	10	Yes 2 No	Specify:		Specify	White	2
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(Specify only highest grade	e com <i>pleted)</i> College (1-4or 5+)	lite. DO	NOT use retired		king			
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John Talahan Talahan Talahan Talah	Thompson	405 85 111	A (2)	Bertha		Carew	04-4- 71	2- 4-1
19e. Informent's Name/Relationship (Ty) Dorothy Strausbaug				and Number or Ru				
20a. Method of Disposition	20b. Pla	ace of Dispositi	on (Neme of			nery V1. 20c. Location -		
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21. Signature of Funeral Service License			ame and Addre	al Cardens	3-19-99	TTIIIOIITU	ill, Flo	тутани
10		Mit	chell-V	liedefeld	Home, I	nc.		
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Part II. Other significant conditions con		iting in the unde	orlying ceuse giv	ren in Part I.	-	obacco use coi		
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State of Maryland / Department of Health and Mental Hygiene

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iner	4	a. Fecliity Nema (If not institution, given				4b. City, Town, or		10.000		
	ų,	MERCY MEDICAL			William A Ven	BALTI			TETIMORE	
l r			Sax 7. Age	a (In yrs. lest birthd Yrs	Months Day			y, Year)	9. Birthplace (St Country) Marylan	eta or For d
		0a. State 10b. County		10c. City, Town or	r Location				10d. Insid	la City Lir
Ď	I	Maryland Baltim	ore City							Yes 2
Funeral Director	10	0e. Street end Number 4319 Groveland A	venue		10f. Zip Code 21215			10g. Citizen of V U.S.A.	Whet Country?	
ò		Marital Status Maver Married 2 Married Widowed 4 □ Divorcad	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Yeer or Detes:	Ever in U,S. 1	3. Was Decedent of If Yes, specify Cu		Specify Yes or Norto Rican, etc.)		ce - American Indie ck, White, etc. v: Black	n,
Completed	(Specification (Speci	15. Decadent's Ec (Specify only highest gre Elementery/Secondary (0-12)	da completed) College (1-4or 5	+) (G	cedent's Usuel Occ ive kind of work don e. DO NOT use retii	e during most of wo	orking	16b. Kind of Bu	usiness/Industry	
		none 7. Father's Nema (First, Middle, Last,	none		ione	18 Mother's Na	me (First, Middle		nel	
To Be		Rodney Johnson					ra Osman	, waroon Sumen	16/	
-		9e. Informent's Neme/Relationship (Type, Print)	19b. M	aiting Address (Stree	et end Number or R	lurel Route Numb	er. City or Town.	State, Zip Code)	
		Barbara Osman/mo	ther	431	9 Grovela	and Avenue	e,Baltim	ore, Mar	ryland 21	215
	20	De. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☑ Other (Specification)		20b. Place of Discemetery, of	sposition (Neme of cremetory or other p	leca)	Date	20c. Location -	City or Town, Stet	θ
	2	1. Signature of Funerel Service Licens On a Ld S.	Tale Direc		State And Baltimore			V. Balti	more Str	eet
	1 2	3a Penti. Enter the disease, or come chock, or heart failure. List only	plications thet causad	the deeth. Do not	enter the mode of dy	ying, such es cardie	c or respiretory e	rrest,	Approx	mete Betwee
Examiner	di re	nmediate Cause (Final isease or condition southing in death) equentially list conditions, any leading to immediate	b EXTRE	Due to (or es e con	sequenca of):		WK 561	f	4,	days
	a C	equentially list conditions, eny, leading to immediate ause. Enter Underlying euse (Diseese or Injury let initiated events	C							
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Physician/	Pe	ert II. Other significant conditions of		t not resulting in the	e underlying cause g	jiv <i>e</i> n in Pert I.	23b. Did	V	ntribute to the cau	
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by Physician/	Pe	ert II. Other significant conditions of		t not resulting In the	e underlying cause g	jiven in Pert I.	1 □ 24a. Wes	Yas 2 No	24b. Were autor evelleble prompletion of deeth?	4 Unk
Completed by Physician/		5. Was cas <i>e referre</i> d to medical	ontributing to death bu	t not resulting in the	e underlying cause g		1 □ 24a. Wes	en eutopsyrmed?	24b. Were autor evelleble prompletion of deeth?	4 ☐ Unk
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Please Type or Print In Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Amended#26 perPhy G769 3/18/99 EW Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death Pigue Jeanette E. Month Day Year **Physician** March 16, 1999 1:00 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joppa Harford 1010 Trimble Road If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 KF 216-30-5819 64 Director July 2,1934 Maryland Usual Residence of Decedent 10a. Slate 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2X No Edgewood Directo Harford Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 must be 21040 United States 805 A Windstream Way Norms 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes ≥ 2 ②No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: White Specify: þ 3 ☐ Widowed 4 Ø Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home Ilnknown permit. Pages 1 and 2 should be file Department of Hostin and Mental Hy Important: If Nem 27 is marked other any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grace Louise Heatcoat James Henry Hodge 19a. Informent's Name/Reletionship (Type, Print) Daughter 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1010 Trimble Road Joppa, Maryland 21085 Mrs. Yvonne C. Corio 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 3/19/1999 Baltimore, Maryland 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. arroth 21222 2 7922 Wise Ave. Dundalk, Maryland the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that a shock, or heert failure. List only one cause of the shock of the sh Approximate nterval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical LUNG ETASTATIC Examiner Due to (or es a consequence of) Examine physiciarrand s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 certificate be Physician/Medical Due to (or as a consequence of): P.O. 23b. Did tobacco use contribute to the cause of death? the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 s 1 ☐ Yes 2 No 1 TYes 2 No Be 25. Was case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home Pesidence 6 MOther (Specify) Residence Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 10 After this 27. Menner of Death Neturel 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attanding 5 Pending investigetion s after death.

I Director: After death of the further of the furt 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \(\text{Homicide} \) To the Hospital o within 24 hours af To the Funeral Di completely filled is Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certified 03355/ Hohaus allopar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 59 Dr. Boltimore, 21237 9000 FRANKLIN AUERBACH, MICHREL

Registrar

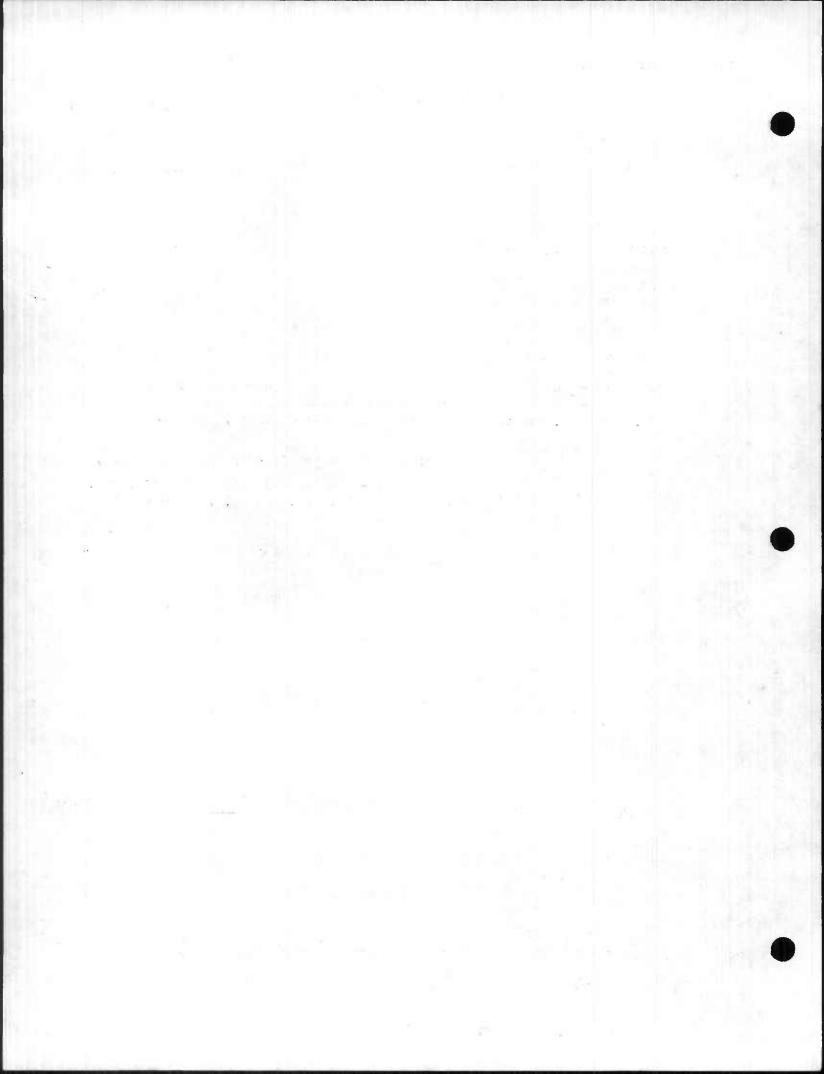
State

31. Date filed (Month, Day, Year)

MAR 1 8 1999

Loseka

32. Registrar's Signature



Please Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Data of Death Yaar Month PARSONS 10:35 AM ETHEL 1999 MARCH 16 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death CENTER BALTIMORE HARBOR HOSPETAL If Under 24 Hrs. Hours Min. 7. Aga (In yrs. last birthday) If Undar 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 6. Sax 8. Data of Birth (Month, Day, Year) Months Days 1 M 2 X F 214 54 1395 78 April 30,1920 Virginia Usual Rasidanca of Decedant 10c. City, Town or Location 10d. inside City Limits 10a. Stata 10b. County 1 X Yas 2 No N/A Maryland Baltimore 10g Citizan of What Country? 10e Street and Number 10f. Zip Code 1069 Church Street 21225 U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, 12. Was Decedant Ever in U,S. Armed Forces? 11. Marital Status Black, Whita, atc. 1 ☐ Yas 2 🎇 No if Yes, Giva 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 XNo Specify: Specify: White 3X Widowed 4 ☐ Divorced Yaar or Datas: 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Dacadant's Education (Specify only highest grada complated) Elementary/Sacondary (0-12) Collega (1-4or 5+) 10th Homemaker Own Home 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Emma Spradlin John McGuyer 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Clarence Parsons 2836 Louisiana Avenue Baltimore, Maryland 21227 20b. Placa of Disposition (Nama of cemetery, crematory or othar placa) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 3/19/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Spacify) Cedar Hill Cemetery 22. Nama and Addrass of Facility 21. Signatura of Funarai Sarvica Licensee Gonce Funeral Home P.A. terone manuouds 4001 Ritchie Highway Baltimore, Md. 21225 23a. Part1. Enter the disease or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate intarval Between Onset and Death Immadiata Causa (Finai SEPTIL SHOCK DAY disease or condition rasulting in daath) Due to (or as a consequenca of): CHOLANGITIS Sequantially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disaasa or injury that initiated surantials) GALL STONES that initiated avants rasulting in death) Last Dua to (or as a consequanca of): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contributa to the cause of death? 1 Yas 2 No 13 Frobably 4 Unknown HYPERTENSION 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was an autopsy RIGHT RENAL MASS. 1 Yas . 2 No 1 Yes 2 No 25. Was case rafarred to medical axaminar? 26. Piaca of Death (Check only one) Hospital Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yas 2 No 2 ER/Outpatient 3 DOA Inpatiant 28a. Date of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Manner of Death 28b. Tima of 28c. Injury at Work? 12 Natural 5 Pending invastigation 1 Yas 2 No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Straet and Number or Rural Routa Number, City or Town, Stata) 28e. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Spacify) 4 Homicida

The law requires that the death certificate be executed physician end s the burlei-transit Division of Vital Records, P.O. Box 68760. attanding pl for use es t ed by the a sign 1 be certificate hes t director After this funeral or Attending

Physician

/Medical

Examiner

Funeral

Director

na 23a or 28a-1 show

r than "natural", or itams

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mentai Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exercises once.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

Director

Funeral

by

Completed

2

Physician/Medical Examiner

Completed by

Be

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29a. Certifian

(Check only one)

the Marylend

with

death

Certification: filled in by 24 hours a Hospital Medical To the Hoss within 24 ho To the Fund completely f

State

Registrar

31. Date filad (Month, Day, Year)

29b. Signatura and titla of certifiar

ilcant

MAR 181999

32. Registrar's Signatura

30. Name and address of person who complated causa of death (Itam 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at tha time, data and placa, and dua to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

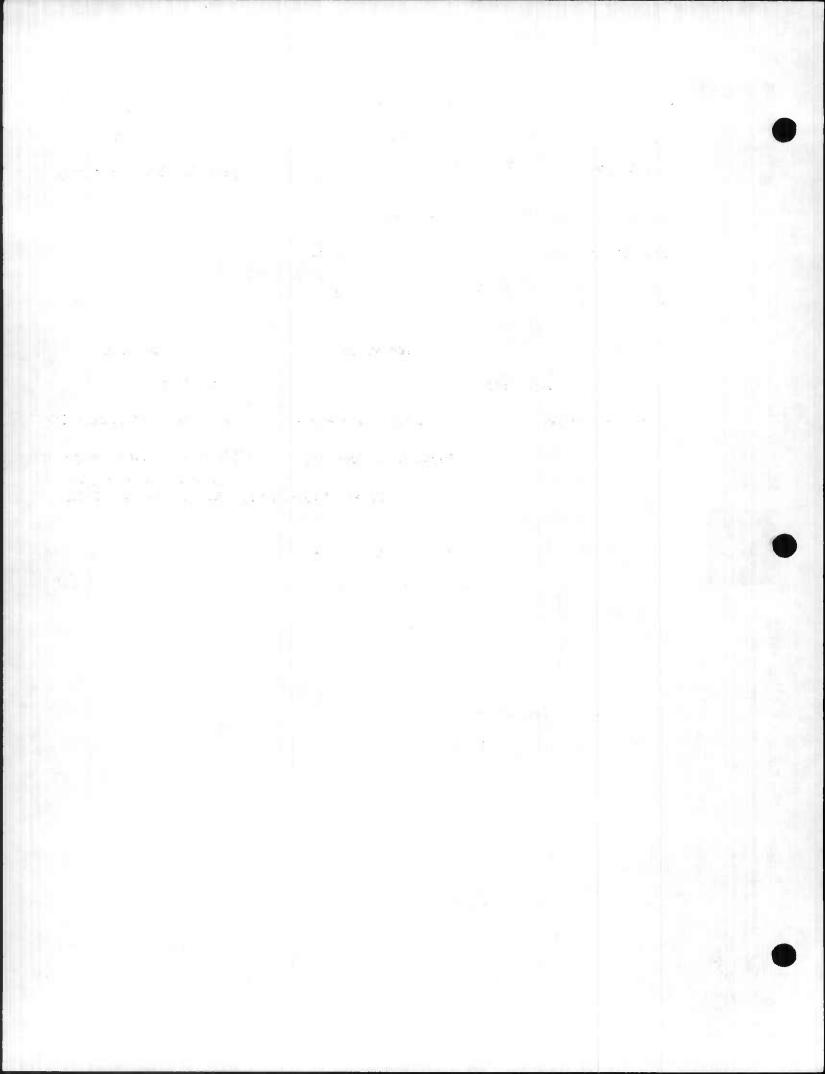
29c. License number

13132

29d. Data signed (Month, Day, Year)

MARCH 16 1999

3001 SOUTH HANOVER STREET BALTIMOKE MD SRIKANTH RAMACHANDRUN1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** MARCH TAR /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BACTMORG
If Under 24 Hrs. 8. Date of Birth
(Month, Dey, Year) (ENTER | Hunder 1 Year HOPKINS GERIATE N/A IC 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Months Days 191-20-3943 **Director** PA Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 X Yes 2 No N/A BALTIMORE Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 412 S. NEWKIRK ST. U.S.A.

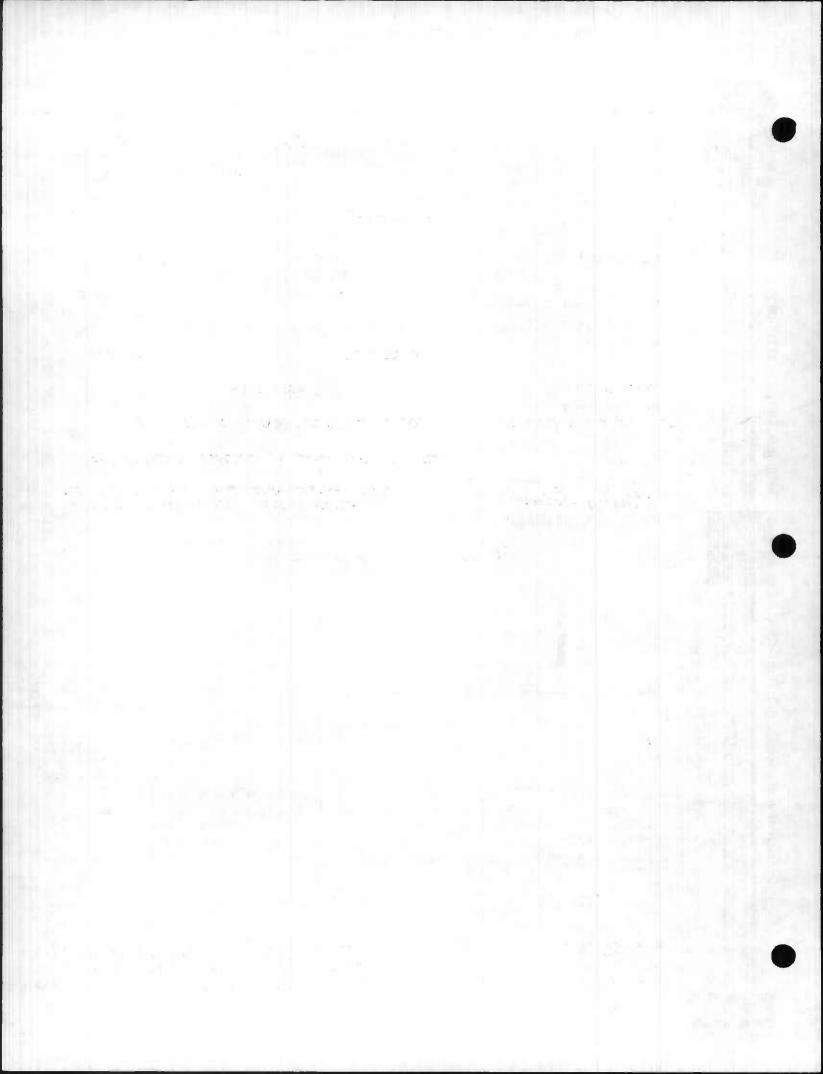
14. Race - American Indian, 21224 Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: filed within 72 hours after 1 Never Merried 2 Married Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: WHITE 2 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 HOUSE WIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) 12 should be fi and Mental H is marked of ANTHONY GRANDOVIC MARY LODER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Pages 1 end 2 siment of Health an ISABELLE THOMAS/DAUGHTER 602 S. QUAIL ST. BALTIMORE, MD 21224 other altimore. 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State ty Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Depertment of Important: If any Injury or once. GREEK ORTHODOX CEMETERY 3/17/99 WOODLAWN, MD 21. Signature of Funeral Service License 22. Name end Address of Facility BRADLEY-ASHTON-MATTHEWS FUNERAL HOME, INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tall bach 2134 WILLOW SPRING ROAD DUNDALK, MD 21222 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 5 min TYOCARDIAL WEARCTTON Examiner Due to (or es e consequenca of): Examiner the death certificate be executed as the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): P.O. Box 68760 Physician/Medical Due to (or as a consequence of) 950 for signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 DUnknown HTN þ Division of Vital Records. 8 24b. Were autopsy findings evallable prior to completion of cause of death? 24e. Was en autopsy performed? page 2 should Completed M 1 Yes 2 No 2 PNo To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 wursing Home 5 Residence 6 Other (Specify) To After this 28e. Date of Injury (Month, Dey Year) 27. Menger of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 1 Natural 5 Pending investigation after death. 1 Yes 2 No 2 Accident 281. Location (Street end Number or Rurel Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homiclde within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier yagi D 0054067 MIZ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHNS HOPKINS GERINTR IC BAYHEN CIRCLE, BAITMONE, MIS Gerialvic Ct 505 YASAR, JH 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State

DHMH 16 Rev 6/95

Registrar

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State of Maryland / [

	2. Date of Deeth				3.	Time	of D)
Certificate of Death	Reg. No.	2	1	U	U	0	6	
Department of Health and	Mental Hygiene	0	0	0	0	0	~	

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	Physician /Medical	_	Decedent's Name	ee Phil				F.P					2. Date of De Month FEB.	Day 21, 199	Year	3. Time of 12:1	of Death
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0,	rificeta be axacuted ng physician end as the burial-transit		equantially list cor any, leading to im ause. Enter Undai ause (Disaase or lat initieted events	nditions, mediete rlying	b	Chronic Alcoholism Dua to (or as a consequenca of):									1		
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Divi	ospital or Attant hours after deat meral Director: y filled in by the		4 Homicide	determin	ed 25a.P	lece of Injury uilding, atc. ((Specify)				- 4-		City or To	own, Stete)			
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29c. Licensa number

ass of person who completed cause of death (Itam 23a) (Type, Print)

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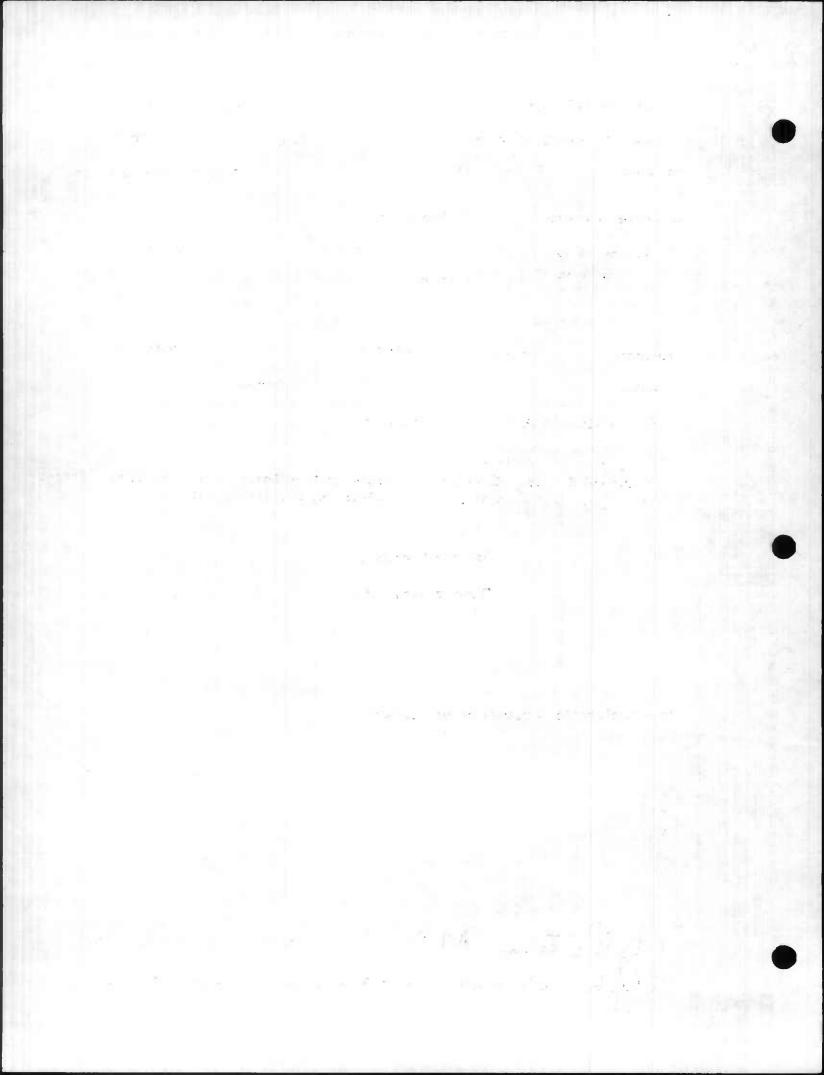
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Time 111 Penn Street, Baltimore, Maryland 21201

29d. Data signed (Month, Day, Year)

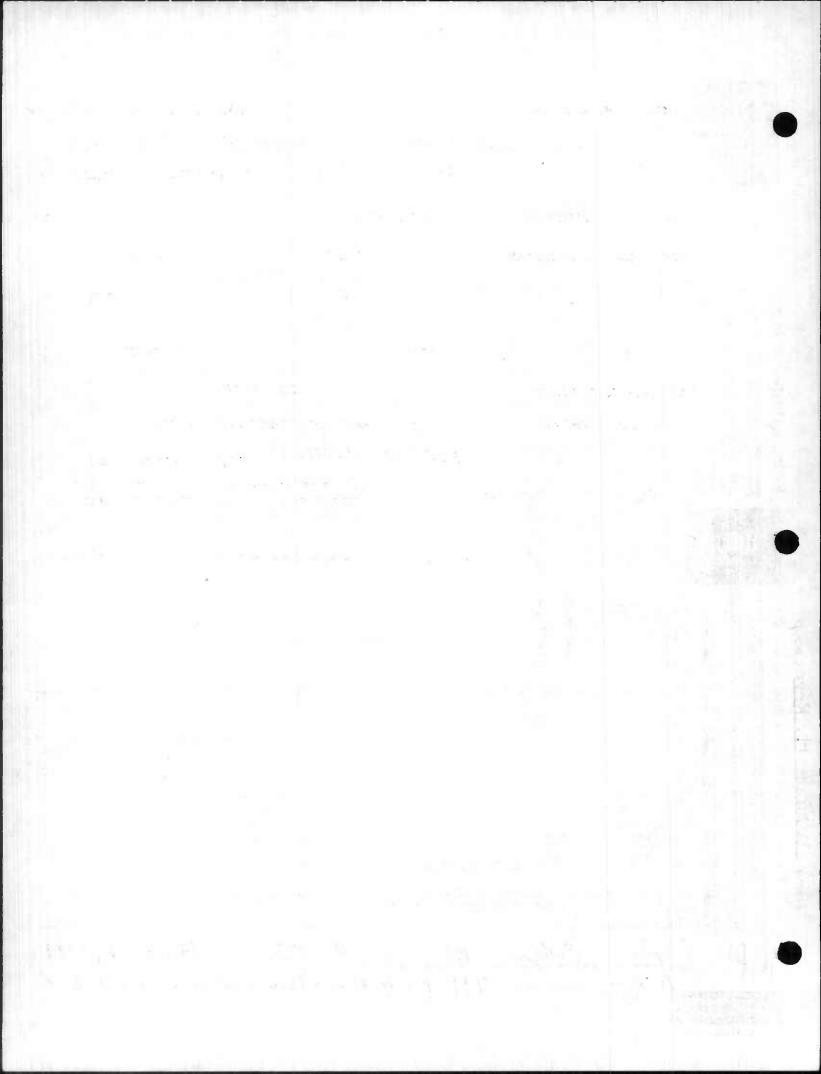
FEB. 22, 1999

State Registrar



					Ce	rtific	ate of	Death		Reg. No.		0009
Physician	1	Decedent's Name (First, Middl	a, Last)						2. Date of De Month	Day	Year	3. Time of Death
/Medical	ı	WILLIAM H. ROV 4a. Facility Nama (If not institution		mbar)				4b. City, Town, o	Marc r Location of Deat	4c. County	99 of Daath	400 pn
		Charlest	own Ca	re C	enter			caton	wille	Ba	Ltin	nore
Funeral Director		5. Social Security Number 213-07-7579	6. Sex 1⊠M 2□F	7. Age (In y	rs. last birthday) 84 Yrs.	If Un Monti	dar 1 Yaar ns Days	If Under 24 Hr Hours Min	s. 8. Date of Bir	th ly, Year)	9. Birth	place (State or Foreigntry) YLAND
		Usual Residence of Decedent		140								
work and and and and and and and and and and	_	10a. State 10b. County	TMODE	100.	Ca mont		TE				1	10d. Inside City Limi
be notified	20		TIMORE		CATON							1 □ Yas 2 🔯 N
23a or	2	10e. Street and Number 709 MAIDEN CHO	CE LANE			107.	Zip Code 21228	3		10g. Citizen of U.S.	What Coul	ntry?
ural, or items 23s or 28s-f show at Examiner must be notified at od by Funeral Director	2	11. Marital Status 1 Navar Married 2 Marr 3 M Widowad 4 Divorced	12. Was Dece Armed Fo 1 Tes If Yes, Giv Yaar or De	rces? 2[XNo re			cedent of I pecify Cub 2 No	dispanic Origin? (an, Mexicen, Pue Specify:	Specify Yas or No rto Rican, etc.)		ce - Americ ck, White, v: WHI	
"natural", adical En	2	15. Decedent (Specify only highes	's Education		16a. Dece	dent's U	sual Occup	ation	orkina	16b. Kind of B	usiness/in	dustry
than the M	1	Elementery/Secondery (0-12)	College (1	-4or 5+)	LAWYE:		use retire	during most of wid)	DIKING	ATTOR	NEY	
d other	ט	17. Fathar's Name (First, Middla,						18. Mothar's Na	ame (First, Middle	Maiden Suman	na)	
end Mental Hygie a marked other t aumatic event, tr	0	BERNARD W. ROVI	CAMP					LILLY	HANNA			
A pur		19e. Informant's Name/Relations			19b. Mailir	ng Addre	ess (Street		Rural Route Numb	er, City or Town,	Stete, Zip	Code)
Health e em 27 is rther tra	1	ROBERT ROVECAMP	'SON		3337	GAR	NET E	ROAD BAL	TIMORE,	MD 21234	1	
525	1	20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 4 □ Donetion 5 □ Other (S)	3 □Removal from \$	Stata B	Place of Dispo cemetery, crer ALTIMOR REMATOR	natory o	Vame of or other pla SHINC	TON	Date 3/11/99	20c. Location		
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Depertri Importa eny inju		Soulet (· Lew						G ROAD D		-	
Medical kaminer		Immediate Ceuse (Final disease or condition resulting In death)	a	Due to	5 fac			ment				Years
ng physician end est the buriel-trensit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	C.	Due to	(or as a conseq	uence c	of):					
ise es the bu		that initieted events resulting in death) Last	d	Due to	(or as a conseq	uence o	f):					
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rs effer death. la Director: After the ed in by the funeral Certification:		2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place	of injury - At	home, farm, stre	M eet, fact		Yes 2□No	28f. Location (S City or Tox	Street and Numb m, State)	er or Rura	I Routs Number,
within 24 hours effer death. To the Funeral Director: A completely filled in by the ft Medical Certificati		Check only 2 Medical E	Physician: To the I	sis of examin	nowledge, death	occurre	ed at the tin	ne, dete and plac	e, and due to the	cause(s) and me	nner as si	tated.
Mec Mec		one) 29b. Signature and title of certifier	and menn	er stated.			9c. Licens					
₹ 8	1	Organization and tale of certifier	1							29d. Date signe		
MARIN	3	80. Name and address of person v	no completed ceuse	of death (Ite	<i>)</i> em 23a) (Type, I	Print)	D.	5 1051		March	11	,1999
10		Andres Sa	tazar ·	711	Maio	len	Clopis	e lane,	Caton	ville,	Mp,	21228
State Registrar	3	31. Data filed (Month, Day, Year) MAR 1	8 1999 B	gistrar's Sign	nature	9.	600	(Cal				

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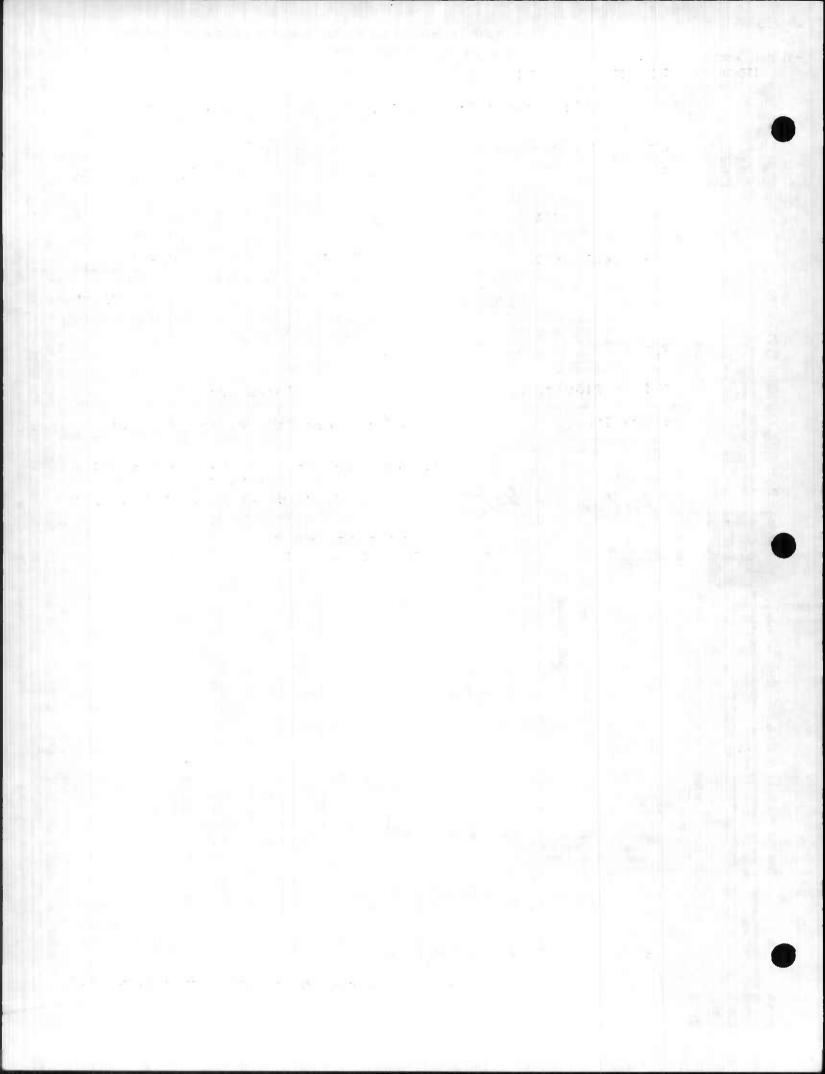
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	1. Decedent's Na	me (First, Middle	e, Last)					2. Date of Death Month	Day	Year 3.	Tima of Death
Physician		Philip	Lamon	t Rido	lev J	Jr.		March 1	1. 1990		:10 A.N
/Medical Examiner	4a Facility Name	(If not institution	, give street and nu				4b. City, Town, or		4c. County		· IV Hal
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	5. Social Security	Number	Hospital 6.Sax	7. Age (In yrs.	last hirthday	if Undar 1 Y	Baltimo	8 Date of Birth		9 Birtholaca	(State or Forei
Funeral	NA	110111001	10XM 2□ F		Yrs.	Months 1D	ays Hours Min.	Nov 27	Year)	Country)	
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3	10a. State	10b. County		10c C	ty, Town or L	ocation				10d i	nsida City Limi
be notified at Director	MD		N/A	100.0	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						X Yes 2□N
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Funeral Director	10e. Street and N	umber				10f. Zip Co	da	10	g. Citizen of V	What Country?	
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ete			t grade completed)		(Give	edent's Usual O	one during most of wo	rking	OD. RING OF BL	usiness/Industr	,
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Be (17. Fathar's Name	a (First, Middle,	Last)				18. Mother's Na	me (First, Middle, M	leiden Suman	10)	
TOE	Phili	p Ridg	ley Sr				Tony	a Gray			
	19a, informant's		-		19b. Mail	ing Address (Si	treet and Number or Ri		City or Town.	State, Zip Coo	(e)
							eer Ct				
Philip Ridg 19a. Informant's Name/Relations Tonya Gray 19a. Method of Disposition 1 Reural 2 Cremation 1 Reural 3 Cremation 1 Donation 5 Other (St			20h		osition (Name of			Md 21202		State	
		3 Removal from		cemetery, cre	ematory or other	r place)	Date	OG. EGGGIOII	Oily or Town,	State	
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		Licensee		2	2. Name and A	ddrass of FacilityBe	tte Fund	ral I	IOm o		
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	shock, or he	eart failure. List	only one cause on e	each line.	tri. Do not er	ner the mode of	dying, such as cardia	or respiratory arre	151,	Inte	oroximate orval Between
n ai	57.10 13.6			SU	DDEN INF	FANT DEAT	H SYNDROME			On	set and Death
	Immediate Cause disease or condit	tion									
ı.	resulting in death	1)	a	Due to (or as a conse	equence of):					
ē	N. H. C.			355.00							
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	that initiated ever resulting in death) Last		Due to (or as a conse	quence of):					
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Sici	Part II. Other sign	nificant conditio	ns contributing to de	eath but not ras	sulting in the	underlying caus	e given in Part I.	23b. Did tol	bacco use co	ntribute to the	cause of deal
Physician/Med									s 2 No		y 4 Unkno
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o Be	examiner?		Hospital:		Wro in		Other				
-	1 Inpatient 2LXEH/Outpatient 3 IDO						4 Li Nursing I	Home 5 Reside			
Certification:	27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurs injury 28d. Describe how injury 28d. Describe how injury 28d. Describe how injury 28d. Describe how injury 28d. Describe how injury 28d. Describe how injury 28d. Describe how injury 28d. Describe how injury 28d. Describe how injury 28d. Describe how injury 28d. Describe how injury 28d. Describe how injury 28d. Describe how injury 28d. Describe how injury 28d. Describe how injury 28d. Describe how injury 28d. Describe how								w injury occur	190	
ati	2 Accident	investig	ation			М	1 Yes 2 No	-			
tific	3 ☐ Suicida 4 ☐ Homicide	6 Could r	ined 200. Piece	of Injury - At I	nome, farm, s	treet, factory, of	ffica	28f. Location (Str. City or Town	reet and Numb	per or Rural Ro	ute Number,
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	29e. Certifier	1 Certifyin	g Physician: To the	best of my kn	owledge, dea	th occurred et ti	he time, dete end plece	e, and due to the ca	use(s) and ma	annar as stated	i.
edicai	(Check only one)		Examiner: On the bi				my opinion, death occi				
Me	29b. Signature an	nd title of certifier				29c. 1 i	icanse number	29	9d. Date signe	d (Month, Dey	Year)
Medica	W O. O.			4				-		, , , , ,	-

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

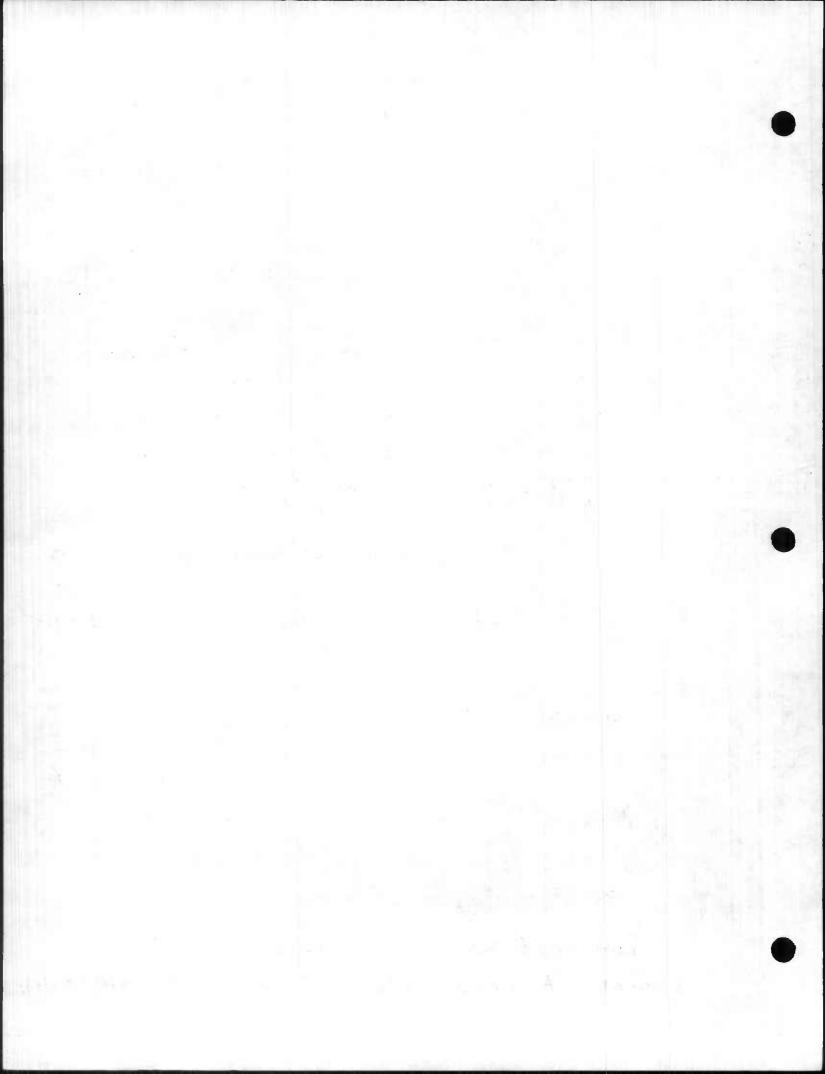
O.C.M.E.

March 12, 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month March 11,1999 **Physician** Eva Ridder 5:30PM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 303 Farwind Dr. Apt. 1D Middle River Baltimore If Under 1 Year Months Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) 2-20-33 Birthpleca (State or Foreign Country) **Funeral** Days 217-38-3361 1□M 2以F 66 Director Germany Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Middle River 1 Yes 2 No Director 6 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code 303 Farwind Dr. Apt. 1D 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. 11. Meritel Status 1 ☐ Yes 2 ☑ No If Yes, Give △ Year or Dates: 1 Never Merried 2 Married the Medical Exami 1 ☐ Yes 2 No Specify: Specify: white by 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) SIDDER Johns Hopkins Hosp, Registered Nurse 17. Fether's Name (First, Middle, Last)
Karl Ridder 18. Mother's Name (First, Middle, Meiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Ida (unk.) 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Spink / niece 15 Crosswind Dr. Shrewsbury, PA 17361 Baltimore, 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete
4 Donetion 5 Other (Specify) 3-13-99 Metro Crematory Catonsville, MD 21. Signature of Funerel Service Licenses 22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 21237 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical tmmediate Cause (Final disease or condition resulting in deeth) gastrointestinal hemovrhage 8 hrs Examiner Due to (or as a consequence of): Circhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): The law requires that the death certificate be exec Alcohol 304ms dependence Box 68760. Physician/Medical Due to (or as a consequence of): Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contributs to the cause of death? Records, P.O. 3 Probably 4 Unknown 1 Yss 2 No Depression þ 24b. Were eutopsy findings evailable prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed certificate has 1 Yes 1 ☐ Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical axeminer? Be 26. Placa of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manper of Death 28e. Date of tnjury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 24 hours after death. 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner es stated
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner stated. 29a. Certifier edicai (Check only one) within 2 ş 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) lugerelbah mo D 44018 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 10 6565 N. Charles St. Baltimore Mg 21204 OBAH LUGENE 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State Registrar

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 3. Time of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth Dey 6:30 PM **Physician** 03 DONALD L. STEVENS MARCH /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Neme (If not institution, giva straat end number) Examiner BALTIMORE CITY CATON MANDE GENESIS ELDER CARE If Under 1 Yaar | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Deys Hours Min t∭M 2□F 79 Yrs. **Director** 218-09-4316 JAN 5, 1920 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland N/A BAltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? r than "natural", or items 23s or the Medical Examiner must be r 2009 Grinnalds Avenue U.S.A.

14. Race - American Indien,
Black, White, etc. Funeral 21230 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) ty Yes 2 No If Yes, Give I 942−1945 Year or Dates: 1 Never Married 3 Married 1 Yes 2 No Specify: Specify: by 3 Widowad 4 Divorced WHITE Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) Receiving Clerk Wholesale Toy House 8th Grade 17. Fathar's Neme (First, Middla, Last) 18. Mothar's Neme (First, Middle, Malden Surname) George Stevens Roeding Carrie 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. informent's Neme/Reletionship (Type, Print) Health Item 27 k Doris M. Stevens (Wife) 2009 Grunnalds Avenue - Baltimore, Maryland 21230

20b. Plece of Disposition (Neme of cemetery, cremetory or other place)

Dete 20c. Location - City of Town, Stete 20e. Method of Disposition 1 XBuriel 2 ☐ Cremetion 3 ☐ Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Md Veterans Cemetery 3/9/99 Owings Mills, Md 21. Signatural of Funerel Service License 22. Name end Address of Fecility Hubbard Funeral Home, Inc. U stimula U 4107 Wilkens Avenue - Baltimore, Maryland 21229 Momao The the disaasa, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or learn failure. List only one cause on each line. Approximete Intarvai Between Onset end Deeth **Physician** Modeler Corcinoma Immediate Ceusa (Final diseese or condition resulting in deeth) /Medical weeks Examiner Dua to (or es(e consequence of) Examiner physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Dua to (or as e consequença of) the death certificate be execu P.O. Box 68760. Physician/Medical Dua to (or as a consequenca of): 98 USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 RUnknown 1 Yes 2 No signed t Division of Vital Records, à 24b. Were autopsy findings eveilable prior to completion of causa of deeth? 24e. Wes en eutopsy performed? Completed certificate hes birector, page 2 s 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case rafarred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 10 1 ☐ Inpatierit 2 ☐ ER/Outpetient 3 ☐ DOA this 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Deeth 28c. Injury et Work? Certification: After 5 Pending Investigation 1 Neturel 1 Tes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Pleca of injury - At home, ferm, street, factory, office building, etc. (Specify) an 24 hour.
The Funeral Direction of the filled in by 6 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier edical (Check only one) 29d. Data signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of certifier D-40521 March 17,1999 30. Name end address of person the completed cause of deeth (Item 23e) (Type, Print) 3350 Wilkers Armus Suite 302

State Registrar

DONALD L.S TEVENS

31. Dete filed (Month, Day, Year) MAR 1 8 1999

DR MANESH

32. Registrar's Signeture

OCHANE

b. posts

Baltimore, MD

ary all a reserved

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death Month 1. Decedent's Neme (First, Middle, Last) 3. Tima of Death Dev DORIS V. STOLLENMAIER MARCH 17, 4:50 A.M. 1999 4b. City. Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death FREDERICK VILLA NURSING HOME CATONSVILLE BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 M 2 XF Yrs. DEC 20,1916 MARYLAND 217-03-8053 Usual Residence of Deceden 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No MARYLAND BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 1106 PLOVER DRIVE 21227 U.S.A. 14. Rece - American Indien Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentery/Secondery (0-12) College (1-4or 5+) 12TH GRADE HOMEMAKER OWN HOME 18. Mother's Nama (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) JOHN F. RIGGS BESSIE KANE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) WAYNE A. STOLLENMAIER(SON) 1106 PLOVER DRIVE - BALTIMORE, MARYLAND 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 X Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) METRO CREMATORY, INC 3/18/99 BALTIMORE, MARYLAND 21. Signature of Funerel Service License HUBBARD FUNERAL HOME, INC. 10 mila 10mas WILKENS AVENUE-BALTIMORE, MARYLAND 21229 other the diseasa, or complications that causad tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, other tellure. List only one causa on each tina. Approximate tntarval Between Onset end Death Immediate Cause (Finel diseasa or condition resulting in death) es mon Sequentially list conditions, if any, leeding to immediate causa. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of):

Physician /Medical Examiner

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Box 68760

P.O.

Records,

Division of Vital Hospital or Attanding Physician: **Physician**

/Medical

Examiner

Funeral

Director

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Hygiene.

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Examiner Physician/Medical Completed by 8 Certification: To

ort II. Other significant conditions o	contributing to death but not rea	sulting in the under	ying caus	sa given in Part I.	23b. Did tobecco use co	ontribute to the cause of death
					24a. Was an autopsy performed?	24b. Wara eutopsy findings svailable prior to complation of cause of death?
. Was case reterred to medical axaminer?	- Nacarial			1 -	eath (Check only one)	
1 ☐ Yes 2 No	Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA	Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Oth	nar (Specify)
. Menner of Deeth Naturel 5 Pending Accident Investigation	28a. Dete at injury (Month, Day Year)	28b. Time of Injury	28c.	Injury at Work? 1 Yes 2 No	28d. Describe how injury occur	rred
3 Suicide 6 Could not b determined			actory, o	ffice	28f. Location (Street end Numb City or Town, State)	ber or Rural Route Number,

Registrar

31. Date tiled (Month, Day, Year) MAR 1 8 1999

and address of person

32. Registrer's Signeture

who completed causa of death (Item 23a) (Type, Print)

MARCELINO ALBUERNE - 1120 N. ROLLING ROAD - CATONSVILLE, MARYLAND 21228

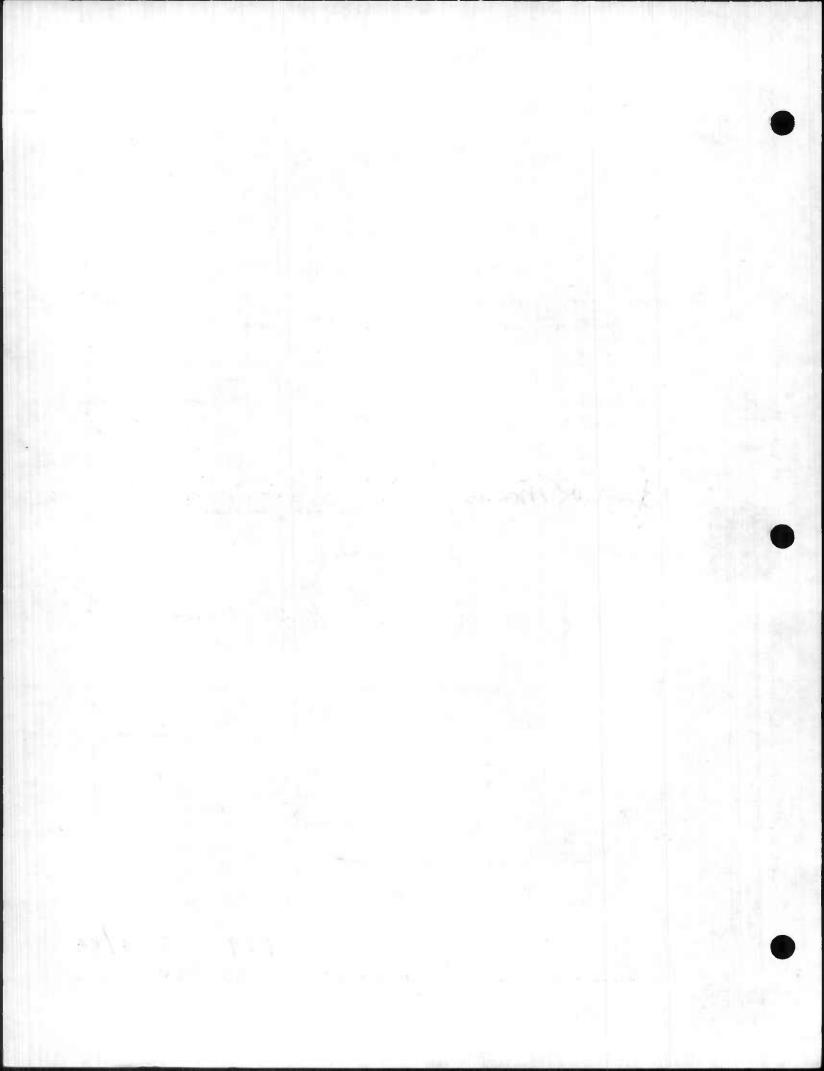
29c. License number

29d. Dete signed (Month, Day, Year)

DHMH 16 Rev 6/95

edical

29b. Signeture and title



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month 1999 1:00 PM Sullivan Anna march 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard county General Hospital Columbia HOWORD If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) Sex Months Days Hours 219-18-8199 APRIL 11,1925 MARYLAND Usual Residenca of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND BALTIMORE CATONSVILLE 10o. Citizen of What Country? 10e Street and Number 10f. Zio Code 719 MAIDEN CHOICE LANE - BR-425 U.S.A. 21228 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 📉 No If Yes, Give 1 Nevar Married 2 Married 1 ☐ Yes 2 No Specify: Specify WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12TH GRADE HOMEMAKER OWN HOME 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) JOHN McLAURINE ANNA FEHER 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) LLOYD R. SULLIVAN (HUSBAND) 719 MAIDEN CHOICE LANE (BR-425) CATONSVILLE, MD 21228 20b. Place of Disposition (Nama of cametery, cremetory or other place) GARDEN 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State DULANEY VALLEY MEMORIAL 4 Donation 5 Other (Specify) 3/18/99 TIMONIUM, MARYLAND 22. Name and Address of Facility 21. Signature of Funeral Service Licenses HUBBARD FUNERAL HOME, INC. 23a. Part | Duter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock on earl failure. List only one cause on each line. 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229 Approximete Intervat Between Onset and Death Immediate Cause (Final modicite disease or condition resulting in death) Over Due to (or as a consequenca of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Failure. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case raferred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Anpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 27. Manner of Death

Physician /Medical Examiner

signed be del

funeral director,

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After

or Attanding Division

To the Hospital or Attandin within 24 hours after death. To the Funeral Director: Af

Physician/Medical

Completed by

Be

Certification: To

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1 Matural

2 Accident 3 Suicide

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29a. Certifier

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Physician

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ma 23a or

Items

I Hygiene.

. Pages 1 and 2 should be filed w tment of Heelth and Mental Hygier hant: If ham 27 is marked other th fury or other traumatic event, the

Department of Important: If any Injury or

72 hours after

21215-0020

altimore. Maryland

Box 68760.

P.O.

Records,

of Vital

Director

Funeral

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Completed

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/Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28h Time of 28d Describe how Injury occurred 28c. tnjury et Work?

28a. Dete of Injury (Month, Dey Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)

D 45157

†© Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

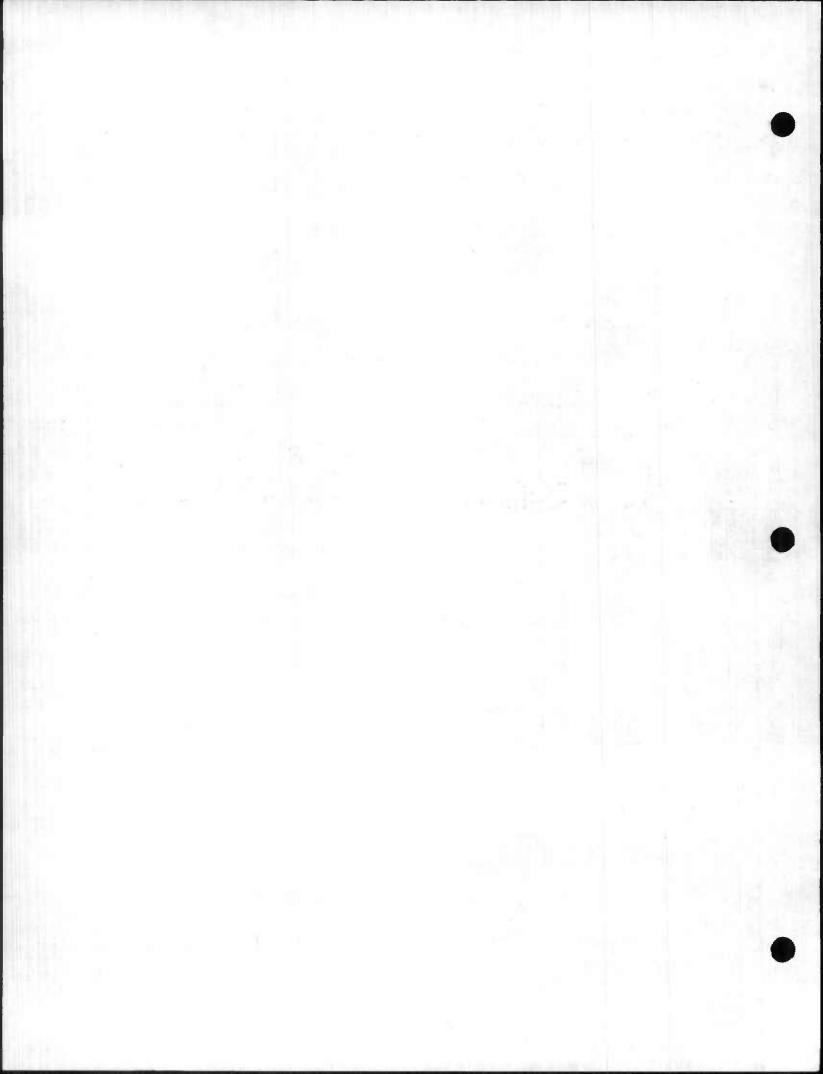
30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

716 MAIDEN WHOICE LAME, SUITE 30 ~ Catomiville, mg zizzo

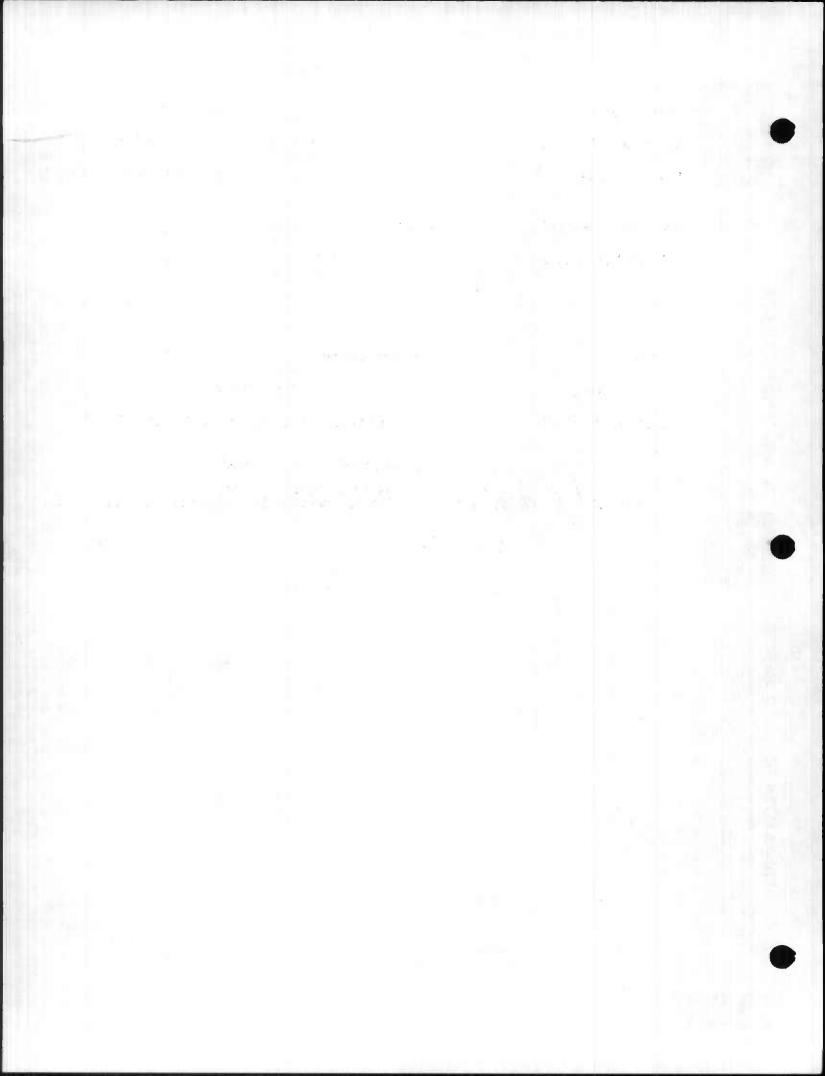
State Registrar 31. Data filed (Month, Dey, Year)

MANAG

32. Registrar's Signature MAR 1 8 1999

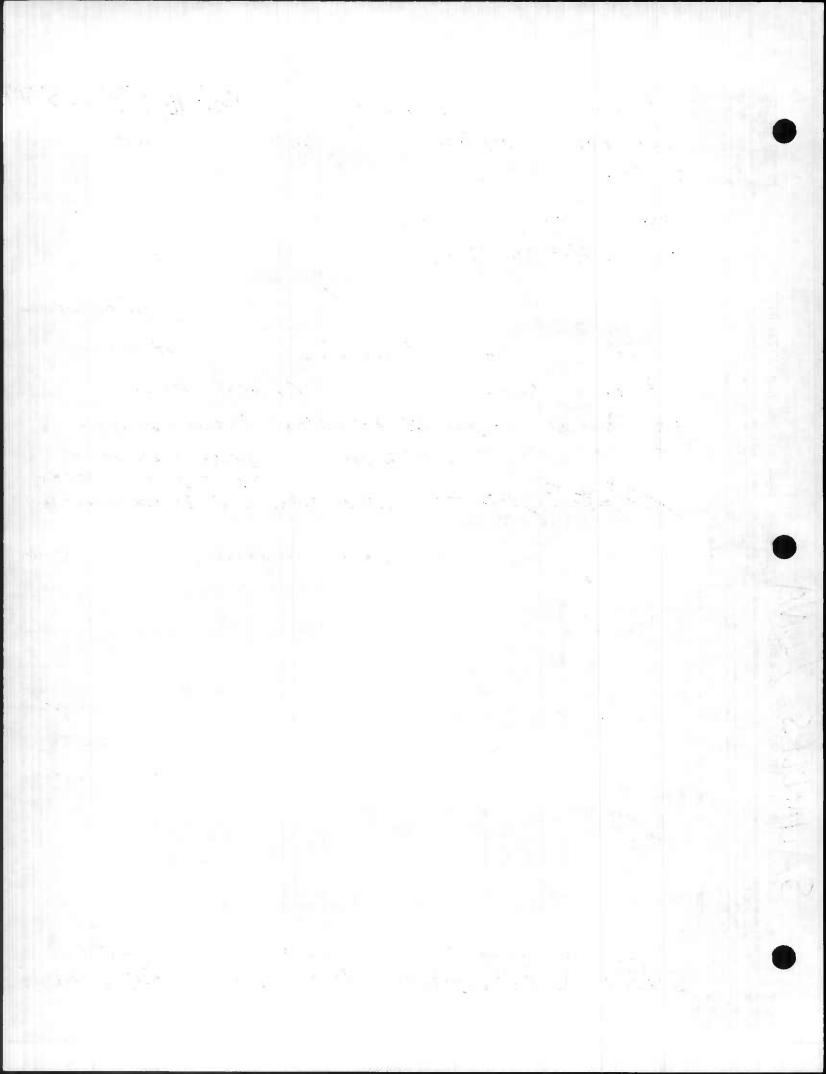


	1. Decedent's Neme (First, Middle	e, Last)				2. Dete of Dee			3. Time of Death	
Physician	John Swisko					March		999	4:30 P.M.	
/Medical	4e Fecility Neme (If not Institution	n, give street and number)		4b. City, Town, or L		4c. County of	-	1.00	I
Examiner	44 Mitchell D				Abingdo	n	Harfo	rd		
Funeral	5. Social Security Number		ge (In yrs. lest birthday	If Under 1 Yeer	If Under 24 Hrs.	8. Date of Birth (Month, Dey			eca (Stete or Foreign	
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ral Director	Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, Town or I	ocation				10	d. Inside City Limits	
0	The second of th								1☐ Yes 2☐ No	
Directo	Maryland Harfo	ord	Abingdor	10f. Zip Code		1	10g. Citizen of Wh	net Count	ry?	
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Funeral	11. Maritel Stetus	12. Wes Decedent Armed Forces	Ever in U,S. 13	Was Decedent of h		pecify Yes or No-	14. Rece			
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Completed	15. Decadent	t's Education	16e. Dec	edent's Usuei Occup	petion	kina	16b. Kind of Bus			
nple	(Specify only highest Elementery/Secondary (0-12)	College (1-4or	5+) life.	e kind of work done DO NOT use retire	d)	'''y				
Con	12th		Cabir	net Maker			Millwork			
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To Be Completed	19e. Informent's Neme/Relations Robert M. Swiske			ling Address <i>(Street</i> Mitchell I						
	20e. Method of Disposition	0/ 30H		position (Neme of emetory or other ple		Dete	20c. Location - C			
	1 ☑ Burial 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (S)					2 /20 /00	Baltimo	re		
a	21. Signature of Funeral Service			eart of Je		3/20/99	Marylar	10		
any Injury DDCs.	X	11 2/1/-	2 1	David J.	Weber, Fu	neral Ho	mes, P.A	A.	21221	
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Examiner	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or es e conse	equenca of):				Į.		
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sicla	Pert II. Other significent condition	ens contributing to death t	out not resulting in the	underlying cause gi	ven in Pert I.	23b. Did t	obacco use cont	tribute to	the cause of death?	
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Certification:	3 Suicide 6 Could r 4 Homicide	ined 286. Piece of In	jury - At home, farm, s ic. (Specify)	treet, fectory, office		28f. Location (S City or Tow	Street end Numbe m, State)	r or Rural	Route Number,	
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State	31. Dete filed (Month, Day, Year)	32. Regist	rer's Signeture		11					



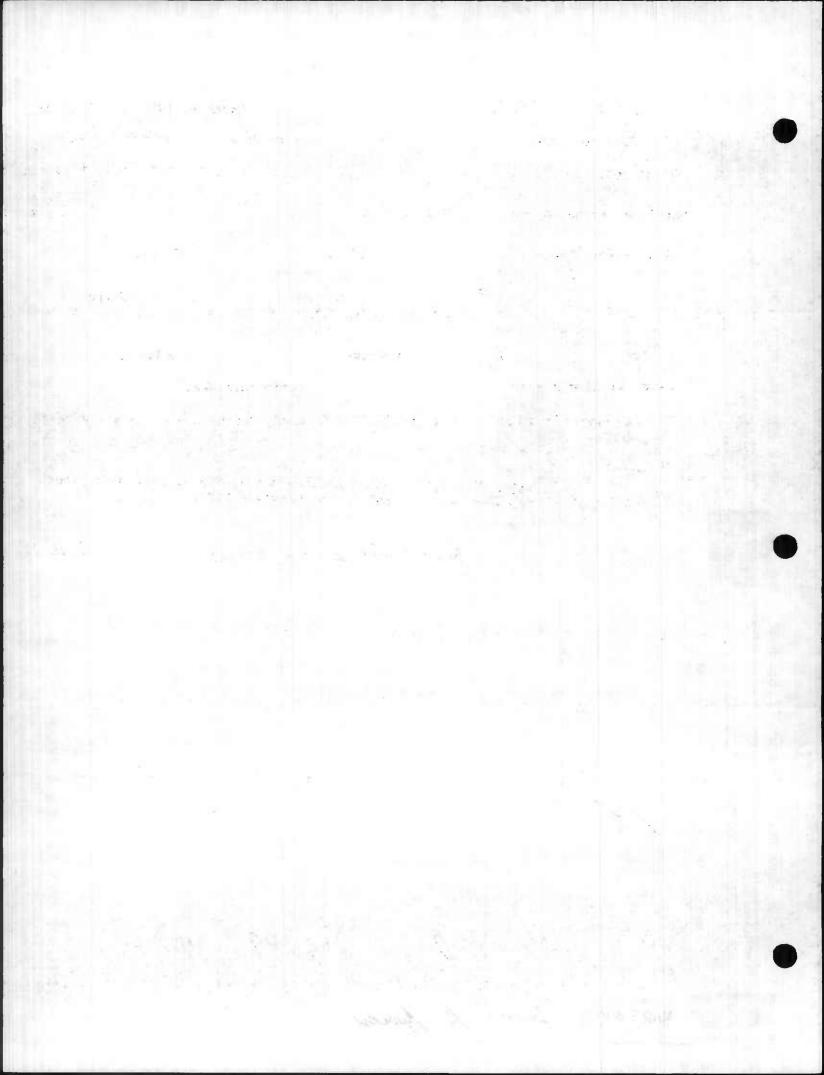
State of Maryland / Department of Health and Mental Hygiene ()

Certificate of Death 1. Decedent's Nama (First, Middla, Last) **Physician** Saunders ONa - /Medical 4c/County of Death 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death **Examiner** HOSP evindale ital BALLIMOR 8. Data of Birth (Month, Day, if Undar 24 Hrs. If Undar 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 6. Sex Birthpiaca (Stata or Foraign
Country) **Funeral** Months Days Hours 2/9-/0-7038 Usual Rasidance of Dacedant 1 M 201F Yrs. **Director** with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r 28a-f show 1 Yas 2 No BALlimore Director MD 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? Item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be re 21215 2503 OLEI USA 14. Raca - Amarican Indian, Ve Funeral death 12. Was Dacedant Ever in U.S. Armed Forcas? 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Maritai Status Black, Whita, atc. 1 ☐ Yas 2 ☐ No 1 □ Navar Married 2 □ Married 1□ Yas 2□No altimore, Maryland 21215-0020 Specify: þ African American 3 ₩Vidowed 4 Divorced Completed 16a. Decedant's Usuel Occupetion (Giva kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "n any injury or other traumatic event, the Med 0058. Elementery/Secondary (0-12) College (1-4or 5+) nmes NA 18. Mother's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be COOK 2 hard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Great Niece Street Lua Lynchburg, Va 24501 Crchard torresi 20b. Place of Disposition (Nama of cematery, crematory or other ptace) 20a. Mathod of Disposition 20c. Location - City or Town, Stata H☐Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata Lausdowne, MD -10 M 4 ☐ Donation 5 ☐ Othar (Specify) P. WYLie 7/HPA 22. Nama and Addrass of Facility 21. Signature of Funarai Sarvice Licansee BACTIMONE, MD. ZIZIT 638 N. Gilnor Street Pert1. Enter the disease, or completations that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximeta Intarval Between Onset and Death **Physician** Immediate Ceuse (Final disaasa or condition resulting In death) /Medical 145 AR ISCHEMIC CARDIO MYOPATHY **Examiner** Due to (or as a consaquance of) Examiner Sequentially list conditions, if any, laading to immadiate causa. Enter Underlying Causa (Disease or Injury that initiated evants rasulting In daath) Last Dua to (or es a consequance of): Physician/Medical Dua to (or as a consequence of): 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 8 1 Yss 2 No 3 Probably 4 Nonknown signed by DIST ASE CORONARY ARTERY Records, þ 24b. Ware autopsy findings aveileble prior to complation of causa of death? Completed 24a. Was an autopsy performed? DEPENDENT DIABETES RELLIM 1 Yas 2 No 1 Yas 2 No certificate 25. Wes casa rafarrad to medical axeminar? Be 26. Placa of Death (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 Yas 2 No 1 Denpatiant 2 ER/Outpatient 3 DOA 캶 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. injury at Work? 28d. Dascribe how Injury occurred Certification: 5 Panding invastigation 1 Natural 1 ☐ Yas 2 Accidant 6 Could not be dataminad Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 D Homicida ò To the Foreral 29a. Cartifiar 1🗹 Cartifying Physician: To tha bast of my knowledga, daath occurred et the time, deta and place, and dua to tha causa(s) and mannar es steted. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 6 29b. Signatura and titla of cartifian 29c. Licansa number 29d. Data signed (Month, Day, Year) 2 050147 of death (Item 23a) (Type, Print) 32. Registrar's Signature State 8 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene 9 9 08672

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death JANUARY 26 1999 4a Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death 7. Age (In yes. last birthday) timore If Under 1 Year If Under 24 Hrs. 8. 6. Sex 1 M 2 F 9. Birthplaca (State or Foreign Country)

M

... Date of Birth (Month, Day, Year) NONE Yrs. Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 DVGs 2 No re 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ery Was Decident Ever in U.S. Armed Jorces? 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 2 No 1□ Yes 2□ No Specify. 3 Widowed 4 □ Divorced 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) INFANT FNFAN 0 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) Known 290 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Re
4 Donation 5 HOther (Specify)
21. Signature of Funeral Service Licensee 600 23a. Part1. Enter the disease, or dorn shock, or heart failure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Immediate Cause (Finat disease or condition resulting in death) twelve homes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to whours ubo Due to (or as a consequence of) Part IL Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 1 nterventricular 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Nem /A No mo thorax Yes 2□No 1 Yes 2 7 No 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

/Medical Examiner Records, P.O. Box 68760 been signed by the should be deteched certificate

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at

altimore, Maryland 21215-0020

filed within

permit. Pages 1 end 2 should be flied withir Department of Heelth end Mentel Hygiene Important: If flem 27 ie marked other than eny Injury or other treumatic event. the

Physician

buriei-transit

Director

Funeral

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Completed

Be 2

Physician/Medical Examiner

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Be Completed

Medical Certification: To

Division of Vitai To the Hospital or Attending Physicien: within 24 hours effector: After this certifica completely filled in by the funeral director; I

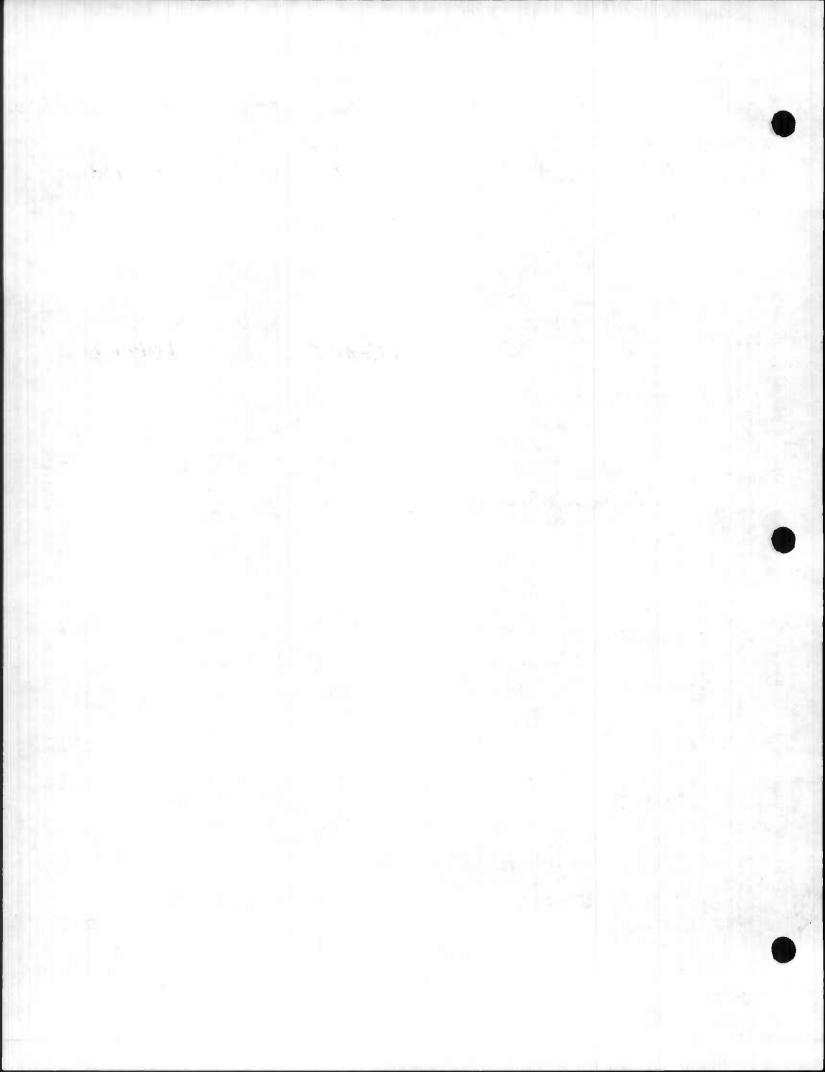
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. tnjury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1□ Yes 2□No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ddress of person d cause of death (Item 23a) (Type, Print) Hopkins Hos

State Registrar

31. Date filed (Month, Day, Year) MAR 1

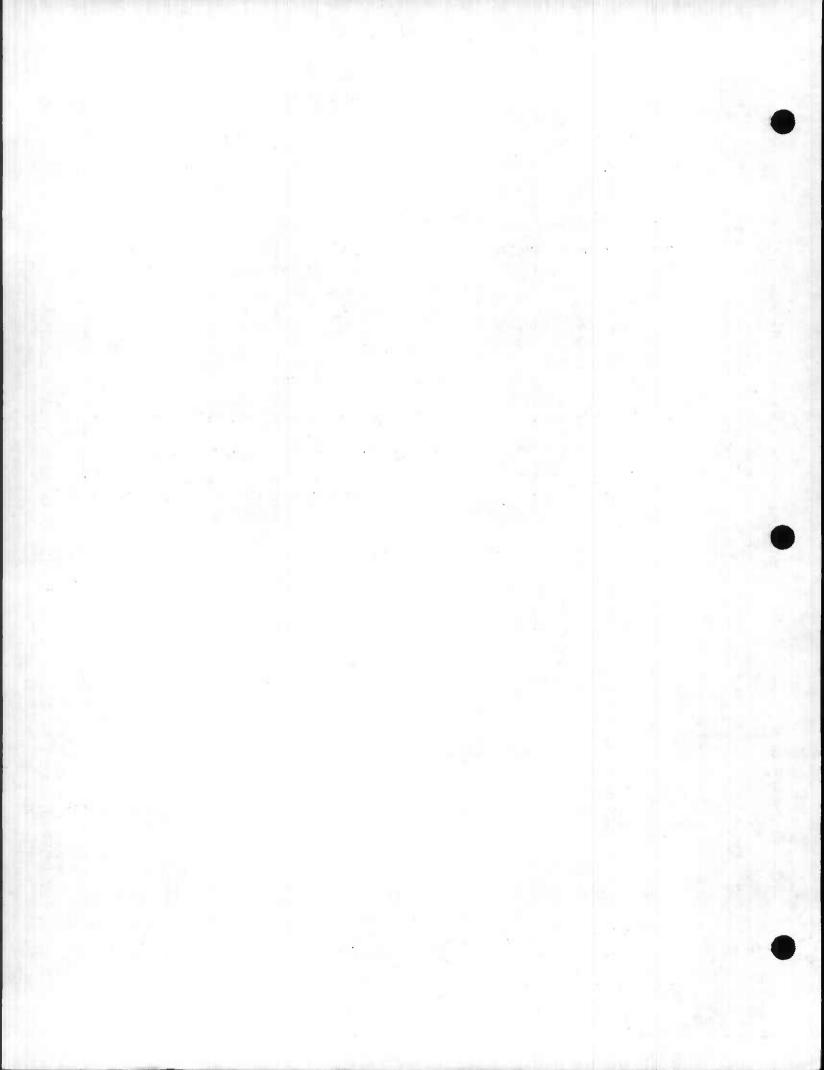
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32. Registrar's Signature



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Pages 1 ar	ury or othe			☑Ramoval from State	CI	ematary, cram AR PARI	sition (Nama of eatory or other place CEMETER	RY	Data 3/18/99	20c. Location - PARAMU	S, N	J	
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DHMH 16 Rev 6/95



Piease Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended#26per Phy G769 3/18/99 EW Certificate of Death 3 Time of Death 1. Decedent's Nama (First, Middle, Last) 2 Date of Death **Physician** 04 Marc /Medical 4b City Town or Location of Death 4a Facility Name (If not institution 4c. County of Death Examiner more timore If Undar 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) Months Days Hours 10 M 2□ F 60 Yes 243-56-7041 NC 11/14/1938 Usuet Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 TYas 2 TNO Directo BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 PLATER COURT 21207 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Datas: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 PLUMBER PLUMBING 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Malden Surname) HERMON SMITH REBECCA ANDERSON 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) ANN FALCON/SISTER 2 PLATER COURT BALTIMORE, MD 21207 20b. Place of Disposition (Name of cematery, crematory or other place) Date 20c. Location - City or Town, Stete 20a Mathod of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 3/14/99 GREENLAWN CEMETERY HARTSVILLE, SC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility STERLING-ASHTON-SCHWAB FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 23a. Pert1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) Physician/Medical Examiner Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Disease or Injury that initiated avants Due to (or as a consequence of) resulting In deeth) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 300 1 Yes 2 No 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Hospital: 1□ Yes 2□No Other: 4 Nursing Home 5 Residence Specify) 2000 Outpatient P 1 Inpatient 3D DOA Dete of tnjury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? Natural 5 Pending investigation 1 Yes 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

certificate be executed Division of Vital Records, P.O. Box 68760, that the deeth The law requires Physician: or Attending

Euneral

Director

r than "natural", or items 23s or 28s-f show

marked other

permit. Pages 1 and 2 should be file Department of Health end Mental Hy Important: If Ilem 27 is marked othe any injury or other traumatic event phose.

Physician /Medical

Examiner

attending physician end for use es the bunal-trans

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Maryland 21215-0020

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After this deeth. Director: A d in by the f within 24 hours of To the Funeral f

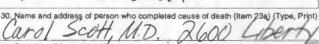
> State Registrar

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(Check only one)

29b. Signature and title of certified

31. Date filed (Month, Day, Year) MAR 1 8 1999

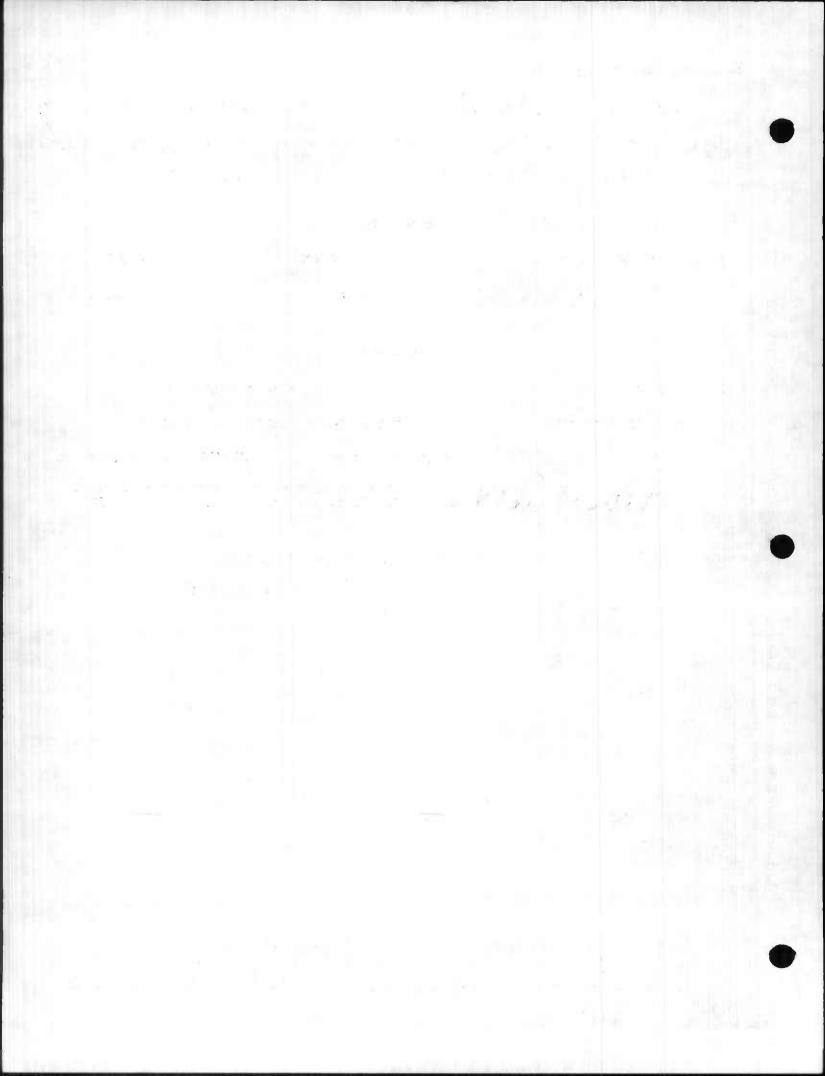


Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and manner as stated.

Madical Examtner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

32. Registrar's Signature



				Cer	tificate	OI I	Dealli			Reg. No.	2 0	10070
Physician	1. Decedent's Name (First, Middle, L Winifred C. Sch								2. Date of De Month	Dey	Yeer	3. Time of Death
/Medical	4a Fecility Name (If not institution, g		er)			4	b. City. Toy	wn. or Lo	March cation of Deat		1999 nty of Death	10:35 PM
xaminer	St. Agnes Hospi		··,				Baltin				I/A	
eral	Social Security Number 6.		Age (In yrs. last	birthdey)	if Under 1		If Under 2		8. Date of Bir (Month, De		*	place (State or Foreign intry)
or	214-20-2432	1□M 2XF	74	Yrs.	Months D	ays	Hours	Min.	01-16-			land
	Usual Residenca of Decedent 10a. State 10b. County		10c. City, To	own or Los	ntion							10d. inside City Limits
-		N/A										1√2 Yes 2 □ No
ecto	Maryland 10e. Street and Number	N/ A	Balti	more	10f. Zip Co	ado				10g. Citizen	of What Cou	21
Ö	3330 Strickland S	Street			2122					U.S.A		ind y t
Funeral Director	11. Marital Status	12. Was Decede	ent Ever in U.S.	13. W	/as Deceden	l of H	ispanic Orio	oin? (Spe	ecify Yes or No		Race - Ameri	ican Indian,
Fun	1 ☐ Never Married 2 ☐ Married	Armed Force		if if	Yes, specify	Cuba	in, Mexican	, Puerto	Rican, etc.)		Black, White	
þ	3√ Widowed 4 Divorced	If Yes, Give Year or Date	es:	1	☐ Yes 2€	J No	Specify:			Spe	city:Whit	te
Completed	15. Decedent's (Specify only highest g	Education rade completed)	10	6a. Deced	ent's Usual C	occupa	ation during most	of worki	ing	16b. Kind o	f Business/Ir	ndustry
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Be	17. Father's Name (First, Middle, Las William Winfield								rederic			
To	19a. informant's Name/Relationship		1	9b. Mallin	Address /S	Street			A Route Numb			ip Code)
	Calvin R. Schutz								en Burn			
	20a. Method of Disposition	•	20b. Place	of Dispos	ition (Name	of			Date		on - City or T	
	1 ☑ Buriel 2 ☐ Cremetion 3 4 ☐ Donation 5 ☐ Other (Spec		ate _		etory or other			0	3/16/9	9 Balt	imore	City, MD
	21. Signature of Juneral Service Lio			22.	Name end /	Addres	ss of Facility	v				
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	23a. Part1. Enter the disease, or co	mplications thet cau	sed the death. D								lason	Approximete Interval Between
n	shock, or heart failure. List on	y one ceuse on eec	n mie.									Onset and Death
l r	Immediate Cause (Final disease or condition	. 1	YXEDEMA	COMA								24 Hours
	resulting in death)	4.	Due to (or es								1	
edical Examiner		b										
Xar	Sequentially list conditions, if any, leading to immediate		Due to (or es	e consequ	uence of):							
cal	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C	Due to for ac	0.000000	anno of):							
ed	resulting in death) Last		Due to (or es	e consequ	rence or).							
M/u		d										
SIC	Part ii. Other significant conditions	contributing to deat	h but not resultin	g in the un	derlying cau	se giv	ren in Part i.		23b. Did	tobacco use	contributs	to the causs of death?
Physician									1	Yes 200	lo 3 Pr	obably 4 Unknow
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should									24e. Was	an autopsy ormed?	8	Vere eutopsy tindings vailable prior to completion of cause
Completed by											0	f deeth?
Cor									1	Yes 2□N	0 }	Yes 2□ No
Be	25. Was case referred to medical examiner?	Hospital:				Oth	or.		h (Check only			
7	1 ☐ Yes 228 No 27. Manner of Deeth	28a. Date of		Outpatient b. Time of			4 L NU	-	me 5 Res 28d. Describe			eify)
tion	Natural 5 ☐ Pending	(Month,	Day Year)	Injury	м	Injur Wor	k? Yes 2⊡!		200. 20001120	non injury or		
fica	3 Suicide 6 Could not	be one plane	Injury - At home	, farm, stre	et, factory, o	_			28f. Location	(Street and N	umber or Ru	ral Route Number,
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edical Certification:		hyaician: To the 6										
~	(Check only 2 Medical Ed	and manner	steted.	ena/or inv	estigetion, in	my o	pinion, deel	in occur	ed at the time	, date and ple	ce, and due	to the cause(s)
8	20h Cignoture and title of agetific	1 1.	1		29c. L	icens	e number			29d. Date si	gned (Month	n, Day, Year)
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						Cei	tificat	e of	Death	9		Reg. No.	0.0	011
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miner	4a Fecility Name	AMBR	give street end nu	imber) TOS P	ITE	TL			BAL	TI.	morE	n/a	ty of Deeth	
neral ector	5. Social Security 218–90–79	944	6. Sex 1 □ M 2√2√F		(In yrs. les 22	st birthday) Yrs.	If Under Months	1 Year Deys	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, De Dec. 2		9. Birthp Coun Md	lace (Stete or Foreign try)
tor	Usuel Residence 10a. State Md •	10b. County n/a		1	-	Town or Lo							1	0d. Inside City Limits
al Director	10e. Sireei and N 803 Lento		e				10f. Zip	2121	2			10g. Citizen of USA	What Cour	ntry?
by Funeral Director	2 82 7	rried 2 Marri	12. Was Dec Armed F 1 Yes If Yes, G Year or I	orces? 2000 ive			Was Deced If Yes, specification		lispenic Orl en, Mexicar Specify:	gin? (Sp n, Puerto	pecify Yes or No Rican, etc.)	- 14. Re BI Spec	aca - Americ eck, White, ify: Bla	etc.
Completed	Elementary/Sec	condary (0-12)	grede completed,) (1-4or 5+))	16a. Deced (Give life.			ation during mos d)	t of worl	king	16b. Kind of		7.44
o Be	12th Grad 17. Fether's Name Ralph Sm:	e (First, Middle, I	ast)			Data	Entr	Y	18. Mothe		ne (First, Middle, ts			l Bank
1	19a. Informent's Kim Smit		ip (Type, Print) M	othe	r			,		_	timore,			Code)
ury or other			3 □Removal from	State	cen	ca of Disponentery, cremands Aubur	netory or o	other plea			Date March 1	20c. Location 9 Balti		
Important: If i any injury or DOCS.	21. Signature of	ey 34	allen			2	501 G	wynr		lls	utter F PKWY Ba	ltimore		•
cian	23e. Botto British	ne diseese, or eart failure. List	complications that only one cause on	caused the	he death.	Do noi ent	er the mod					-		Approximete Intervel Between Onset and Death
ical iner	Immediate Ceuse diseese or condit resulting in death	ion	θ	D	ue to (or e	es e consec	quence of):		Car	rdi	omyo	pathy	1	unknown

The law requires that the death certificate be executed Physician/Medical Exami After this certificate has been signed by the ettending physician end funeral director, page 2 should be deteched for use es the buriel-trans To the Hospital or Attending Physician: The law require within 24 hours effer death.

To the Funeral Director: After this certificate has been sit completely filled in by the funeral director, page 2 should to Be Completed Medical Certification: To

by

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events that initiated events resulting in death) Lest

3 Suicide

29a. Certifier

4 Homicide

Due to (or es e consequence of): Due to (or as e consequence of):

Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Wes case referred to medical examiner? Yes 2□ No Dete of Injury (Month, Day Year) 27. Manner of Death 5 Pending Investigation 1 Naturel 2 Accident

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred 1 Yes 2 No

1 Yes 2 No

1 ¥Yes 2 □ No

24a. Was en eutopsy performed?

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

23b. Did tobacco use contribute to the cause of death?

TX Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date and placa, and due to the ceuse(s) end manner stated. (Check only one) 29c. License number 29b. Signature end litle of certifier

28c. Injury et Work?

ONALDW. EDLOW.

State Registrar 31. Date filed (Month, Day, Yeer)
MAR 1 8 1999

6 Could not be determined

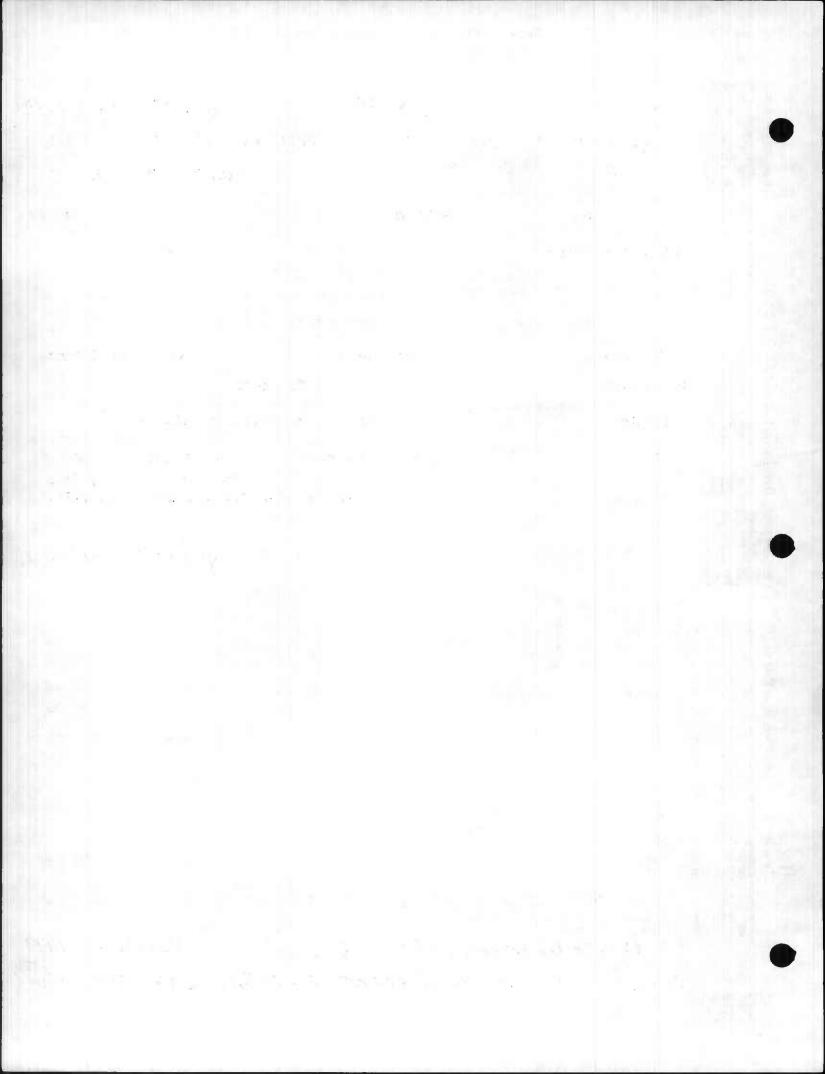
GOODSBMARITAN 32. Registrer's Signature

DHMH 16 Rev 6/95

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of deeth?

1 Yes 2□ No



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 26 per M.D G-769 3/18/99 reb Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Yeer March 8, 1999 5:40 AM Ferne D. Thompson 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Name (If not institution, give street end number) Carroll 209 Bentley Street Taneytown If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year) Jan. 15, 1917 9. Birthplece (State or Foreign 5. Social Security Number 7. Age (In yrs. lest birthday) Days Maryland Months Hours 1 M 2/2/F 212 50 3712 82 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County YYes 2 No Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 824 W. 33rd Street 21211 USA 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Stetus 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Never Merried 2 ☐ Married 1 Yes 2√ No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Year or Detes: 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Willis C. Thompson Unknown 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Richard Thompson Son 1317 W. 42nd Street, Baltimore, Maryland 21211 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 X Buriel 2 Cremation 3 Remove from State 4 ☐ Donetion / 6 ☐ Other (Specify) 3/11/99 Woodlawn, Maryland Woodlawn Cemetery 21. Signature of Funerel Service Licens 22. Name end Address of Fecility Burgee-Henss Funeral Home PA 21211 3631 Falls Road, Baltimore, Maryland Applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Applications that caused the death. Approximate Intervel Between Onset end Deeth Immediate Ceuse (Finel CEREBROUASCULAR ACCIDENTI MONTH disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or as e consequenca of): that initiated events resulting in death) Last Due to (or es e consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown 24b. Were eutopsy findings evaileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 2000 1 Yes 2 No 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Daughter's Residence

Physician /Medical Examiner

Examiner

Physician/Medical

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Completed

Be

10

Physician

/Medical

Examiner

Funeral

Director

the Maryla

after

72 hours

filed within Hygiene.

Pages 1 and 2 should be fis ment of Health and Mantal H ant: If them 27 is marked oth

permit. Pages Department of Important: If It sny Injury or o

Baltimore, Maryland 21215-0020

"natural", or items 23s or 28s-f shoredical Examiner must be notified at

the Medical

Directo

Àq

Completed

Be

physician end s the burial-transit 80 attanding p signed by the a peen : page 2 s certificate director this After this

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Physician: after death.

Certification: a Funeral Director: Aft Dietely filled in by the fur 2 Accident 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homlcide edicai 29e. Certifier the Certifying Physician: To the best of my knowledge, death occurred at the time, dete end placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of certifier

28b. Time of

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28a. Dete of Injury (Month, Dey Yeer)

5 Pending

investigation

1 ☐ Yes 2 No

27. Manner of Death

1 Meturel

28c. Injury et Work?

21117

102

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9

D25052 OWINGS MILLS,

1 Yes 2 No

Other: 4 Nursing Home

D

28d. Describe how injury occurred

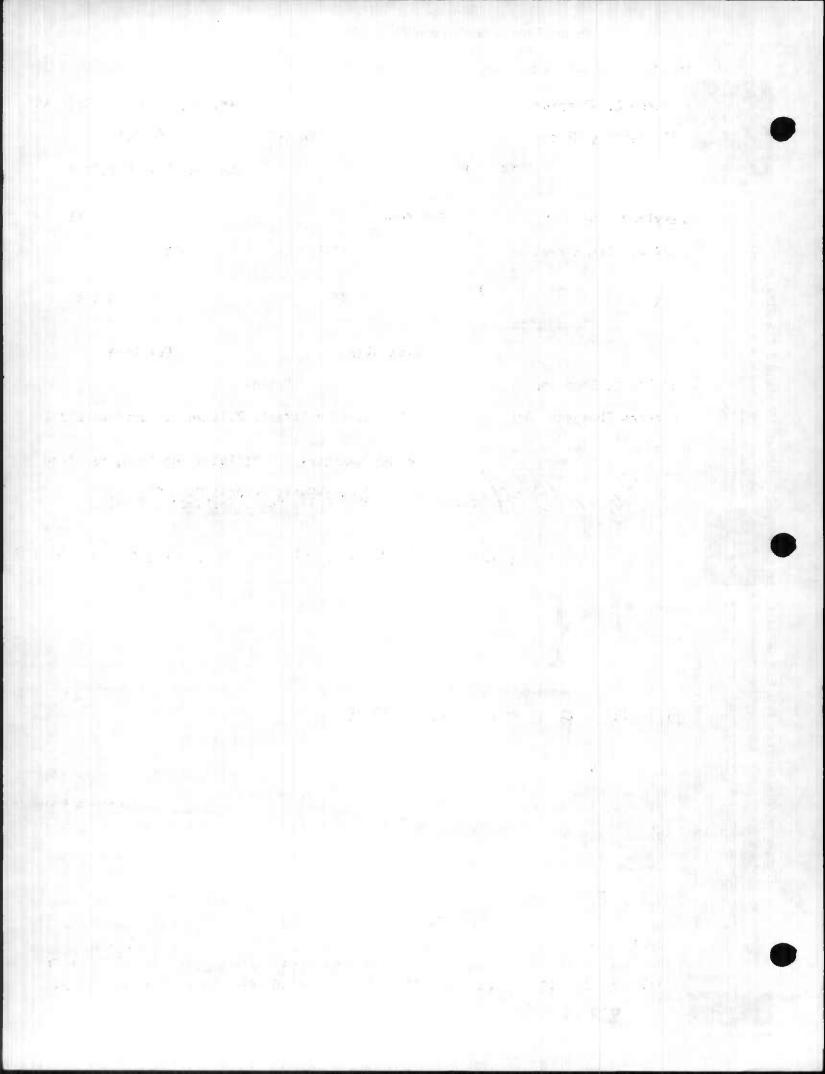
HAFEEZ 31. Dete filed (Month, Dey, Year)

MAR 1 8 1999

32. Registrer's Signeture

Cross Roads 20

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Item: 20b per F.H G-769 3/26/99 reb 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** KATHERINE 1155 PM OMONE MARCH 1999 16 /Medical Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Don Examiner secours 7. Age (In yrs. last birthdey) nore If Under 24 Hrs 8. Date of Birth 6. Sex If Under 1 Yea Birthplace (State or Foreign 5. Social Security Number Months Days Hours 213-28-23 1□M 2XF 1 West Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code nar d Funeral del 12. Wes Decadent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, 11. Marifel Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify ò Blac 3. Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life., DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Educetion (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Ke 1x 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Be an bin Sor 19a. Informent's Name/Reletionship (Type, Print) (days)

MCC TOV CP. FOWIK 19b. Mailing Address (Street and Number or Rulal Route Number, Clty.or Town, State, Zip Code) to, Md 2 0 oarman d 20b. Place of Disposition (Name of cemelery, crematory or other pl 20c. Location - City or Town, State Baltimpre, Md. 20a. Method of Disposition Auburn Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) of Funeral Service Lightsus 22. Name end Address of Facility Home Filter the disease, or complications had ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 21216 Approximete intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Small and large bowel Examiner 30 years Arterios clerosis Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that initialed events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No by 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medicel examiner? Be 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 ☐ Accident

Examine The lew requires that the deeth certificate be executed physician end the buriel-transit Division of Vital Records, P.O. Box 68760 ettending p signed by the e been sig certificate has b director, page 2 s or Attanding Physician: this in 24 hours efter death.

The Funeral Director: After injector filled in by the fu Hospital within 2 To the

director.

funeral

completely

Funeral

Director

th end Mentel Hygiene. 7 is marked other than "naturel", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified at

filed within 72 hours efter deeth

Peges 1 and 2 should be nent of Health and Mentel

: If item 27

permit. Pege Depertment of Important: if any Injury or

Physician

/Medical

Baltimore, Maryland 21215-0020

the Merylend

Registrar

State

edical

nerald word 31. Date filed (Month, Day, Year) 32. egistrar's Signature MAR 18 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature end title of certifier

Masse

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

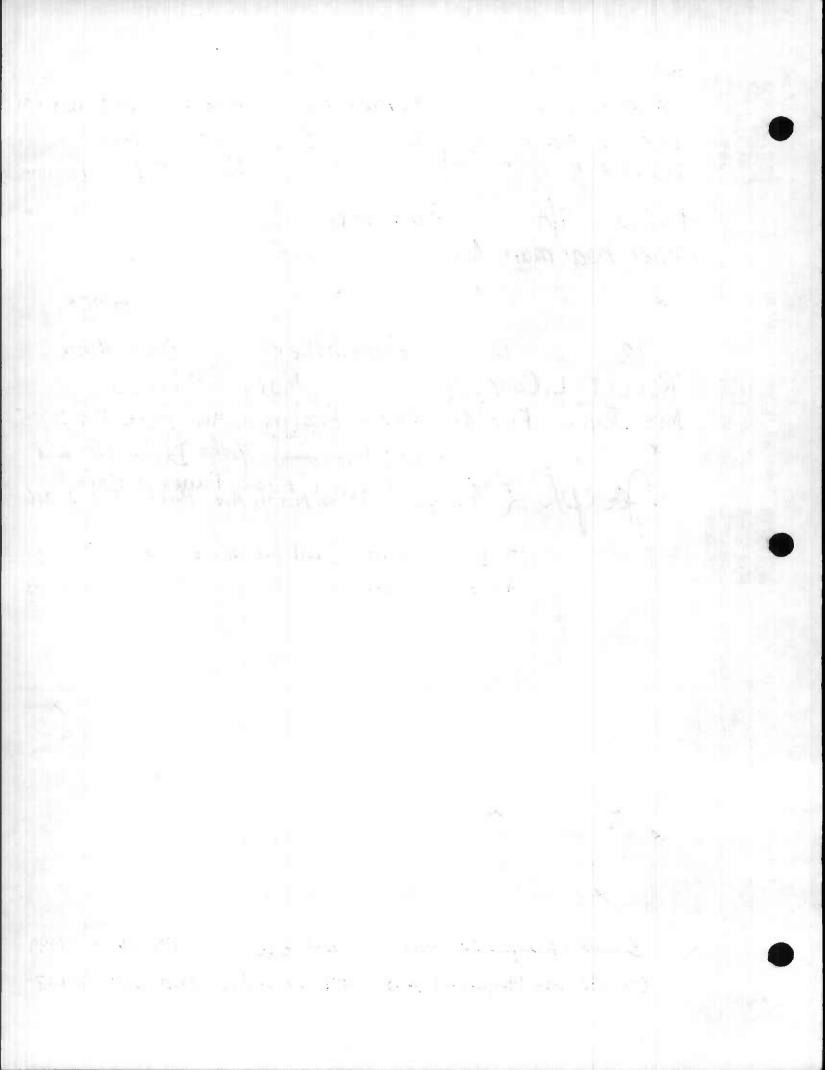
eeds Ave

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Bult MD ZIZZZ

March 16, 1999



1. Decedent's Neme (First, Middle, Last) Month **Physician** William Melvin Voyce march 16 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Glen Burnie North Arundel Hospital Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 5, 1915 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 130 M 2□ F 213 03 2810 83 Director Usuel Residence of Decedent 10b County 10c. City, Town or Location Director Maryland Anne Arundel Glen Burnie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7575 E. Howard Road 21060 U.S. Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Meritel Stetus 1 Yes 222 No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3℃ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry William Elementery/Secondary (0-12) College (1-4or 5+) Coast Guard Clerical 12th Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental F Anna Estella Plumer William J. Voyce Pages 1 and 2 should 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) oyce, 19e. Informent's Neme/Reletionship (Type, Print) 7992 Phirne Road E. Pasadena, Maryland 21122 Betty Fairall altimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 3/18/99 Baltimore, Maryland Cedar Hill Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Servica Licensee 22. Name end Address of Fecility Gcnce Funeral Home P.A. Framerouski 4001 Ritchie Highway Baltimore, Md. 21225 complications that caused tha daath. Do not enter the mode of dying, such as cardiac or respiratory errest, only one cause on each line. 23 Part1. Enter the disaese of shock, or heert failure. List **Physician** ASPIRATION PNEUMONIA /Medical Immediate Ceuse (Finel diseese or condition resulting in deeth) Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part f. P.O. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vinknown DISEASE CHRONIC OBSTRUCTIVE LUNG Records. by Completed FIBRILLATION 24a. Wes an autopsy 1 Tyes 2 Diso vision of Vital or Attending Physician: Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 1 Netural 5 Pending investigation after death. Director: Aft 1 Yes 2 No 2 Accident 6 Could not be 3 Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C

281. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29d. Date signed (Month, Day, Year)

MARCH

9-00 PM

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 Yes 2 No

Approximate Interval Between Onset and Death

4DAYS

24b. Were eutopsy findings available prior to completion of cause of death?

1 Tyes 2 Tho

16,1999

Maryland

White

1999

Quir, 30. Name end address of parson who completed cause of deeth (Item 23a) (Type, Print) M. SHIRAZI, M.D. NORTH ARUNDEL

HOSPITAL. MD 21061.

State Registrar

29a. Certifier

29b. Signetura end title of certifier

31. Dete filed (Month, Dey, Year)

MAR 1 8 1999

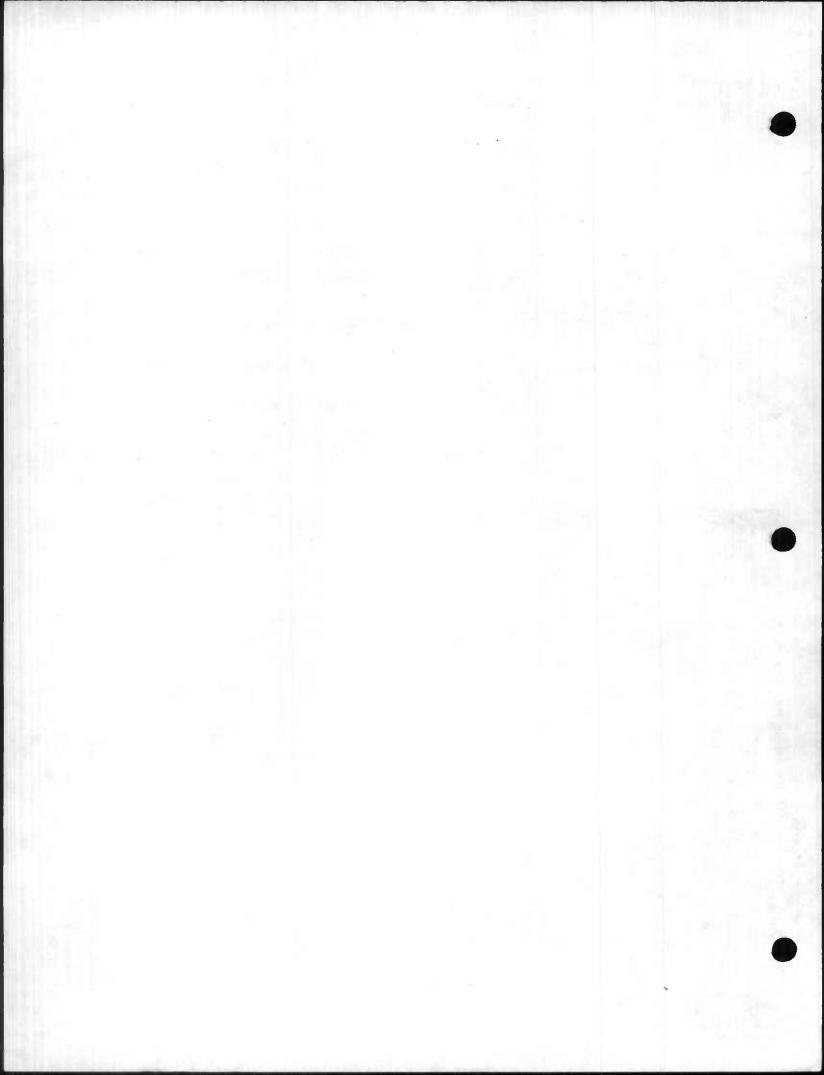


w

29c. License number

D46962

945



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 4c. County of Deeth 7:30 AT MARCH /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner 7930 Philadelphia Rd. Rosedale Baltimore 5. Sociel Security Number If Under 1 Year Date of Birth (Month, Dey, Year) 12-20-26 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 □ F Months Deys Hours 219-18-8340 72 Yrs MD **Director** Usual Residenca of Decedent with the Maryland 10b. County 10a Stete 10c. City, Town or Location 10d. Inside City Limits r 28a-f show MD Baltimore Rosedale 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? "natural", or items 23a or edited Examiner must be 7930 Philadelphia Rd. 21237 USA Pages 1 and 2 should be filed within 72 hours after death name to Mental Hygiane. The marked other than "natural", or fleme 23. Buy or other fraumatic event, the Mental Emerical may not the manage. Funeral 12. Wes Decadent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marttel Stetus Bleck, White, etc. YO Yes 2 No 11 Yes, Give Yeer or Detes: 50-56 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 6 0 Truck Driver Yellow Freight 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be William T. Waters Dorothy Woods 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 7930 Philadelphia Rd. Rosedale, MD 21237 19e. Informent's Neme/Reletionship (Type, Print) Mary E. Waters / Wife 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Department of Important: If any injury or pace. Oak Lawn Cemetery 3-18-99 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Cvach/Rosedale Funeral Home 1211 Chesaco Ave, Rosedale, MD 23a. Pert1. Enter the disease, or complications that caused the earth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** tmmediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner axposene Examiner 1940 Asbestosis 0 Attending Physician: The law requires that tha death certificate be axecuted physician and the bunal-transi Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest Due to (or es e consequence of) Physician/Medical Due to (or as e consequence of) as snar arter sease 980 for signed by the a Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown by 24b. Were eutopsy findings eveileble prior to completion of cause of death? been si 24e. Wes en eutopsy performed? Completed s certificata has b director, page 2 s 1 Yes 2 No 1 Yes 2XNo Be 25. Wes case referred to medical examiner? 26. Pleca of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 (Souther (Specify) HOS pice 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28e. Dete of Injury (Month, Day Yeer) 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident aftar deat 6 Could not be determined 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide 6 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end placa, end due to the ceuse(s) and menner es steted. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end menner steted. 29a. Certifier edical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)

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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

State Registrar

31. Dete filed (Month, Day, Yeer) MAR 1 8 1999

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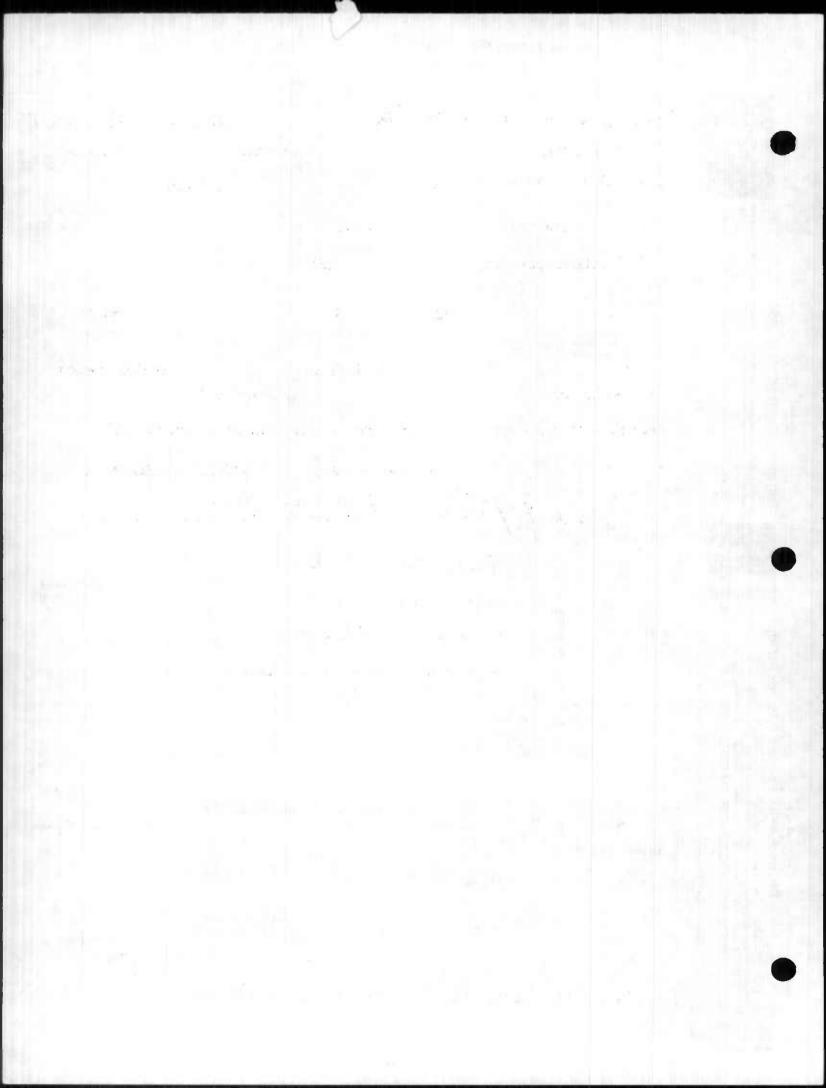
MID

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

606 Hammonds 32. Registrer's Signeture

Baltimore M.D

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth March 17,1999 Month Lillian Wojtas 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Neme (If not institution, give street end number) 7920 31st. Street Rosedale Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) | 7-16-19 7. Age (In yrs. last birthday) 5. Social Security Number 216-09-7049 Birthplace (State or Foreign Country) 1□M 2X F Yrs. MD Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore MD Rosedale 1 ☐ Yes 2 ☑ No 10e. Street end Numbe 10f. Zip Coda 10g. Citizen of Whet Country? 7920 31st. Street 21237 USA 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Yes 2 No If Yes, Give A Yeer or Detes: Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) 0 Retail Clerk Bata Shoe Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Henry Wojtas Mary Kurzla 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Steta, Zip Code) 19e. Informant's Name/Ralationship (Type, Print) Pamela Brown / niece 7920 31st. Street, Rosedale, MD 21237 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) St. Stanislaus 20c. Location - City or Town, Stete 20e. Method of Disposition 1 N Burial 2 ☐ Cremetion 3 ☐ Removel from State 3-20-99 Dundalk, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility Cvach/Rosedale Funeral Home 21, Signature of Funeral Service Lice e 1211 Chesaco Ave. Rosedale, MD 23a. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart feilure. List only one ceuse on each the. enese Approximete Intervel Between Onset and Deeth Immediata Causa (Finel disease or condition rasulting in deeth) ACUTE MYOCARDIAL INFARCTION 1 HOUR ATHEROSCLERATIC CARDIOVASCULAR DISEASE > 10 YEARS Sequentially list conditions, if eny, laading to immediate ceusa. Entar Undarlying Couse (Disaase or Injury that initieted events rasulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to daeth but not resulting in the underlying causa given in Pert i. 23b. Did tobacco use contribute to the cause of death? HYPERTENSION, SYSTOLIC 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown CHRONIC OPSTRUCTIVE PULMONARY DISEASE 24b. Ware autopsy findings eveileble prior to 24a. Was an autopsy performed? completion of cause of daath? HYPERLI PIDEMIA 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel exeminer? 26. Pleca of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 TNo 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Dascribe how injury occurred 28b. Time of 1 DNaturel 5 Panding investigation 1 Yas 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, straet, factory, office building, etc. (Specify) 4 Homicide

physician and the burial-transit The law requires that the death certificete be axecuted Division of Vital Records, P.O. Box 68760 signed by the a certificate has b Hospital or Attending Physician: 124 hours after death. Funeral Director: After this certifica 24 hours To the Hosp within 24 hor To the Fune completely fi

Physician

/Medical

Examiner

Director

Funerai

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parmit. Peges 1 and 2 should be filed within 72 hours efter death with Department of Health and Mental Hygiena.

The file of Health and Mental Hygiena.

The file of Health and Mental Hygiena.

The most provide a marked other than "natural", or items 23e or market in hury or other traumatic event, the Medical Example.

Physician /Medical

Examiner

Examiner

Physician/Medicai

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Completed

Be

Certification: To

Medical

27. Menne of Deeth

29a. Certifian

1 Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated.

29b. Signature and hits of certifier

31. Dete filed (Month, Dey, Year)

,MD

29c. License number

29d. Dete signed (Month, Dey, Year)

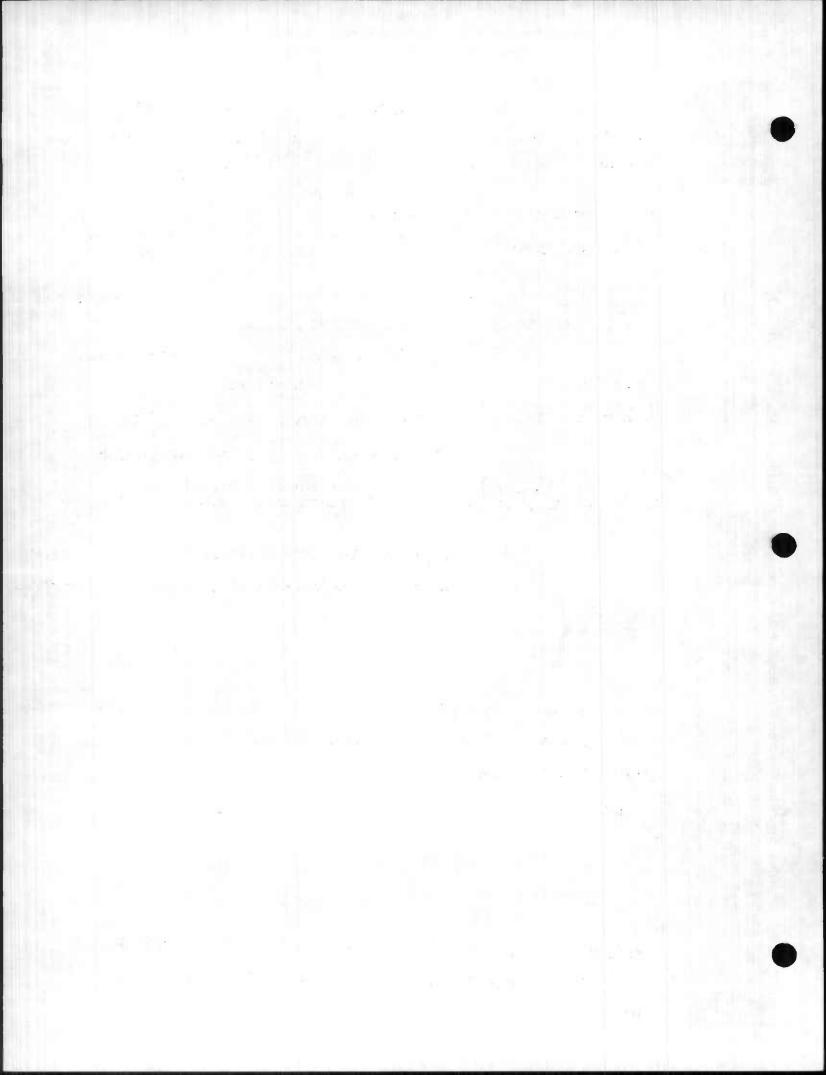
30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print).

PEST) PHILADELPHIA RD:, BALTIMORE, MD 21237

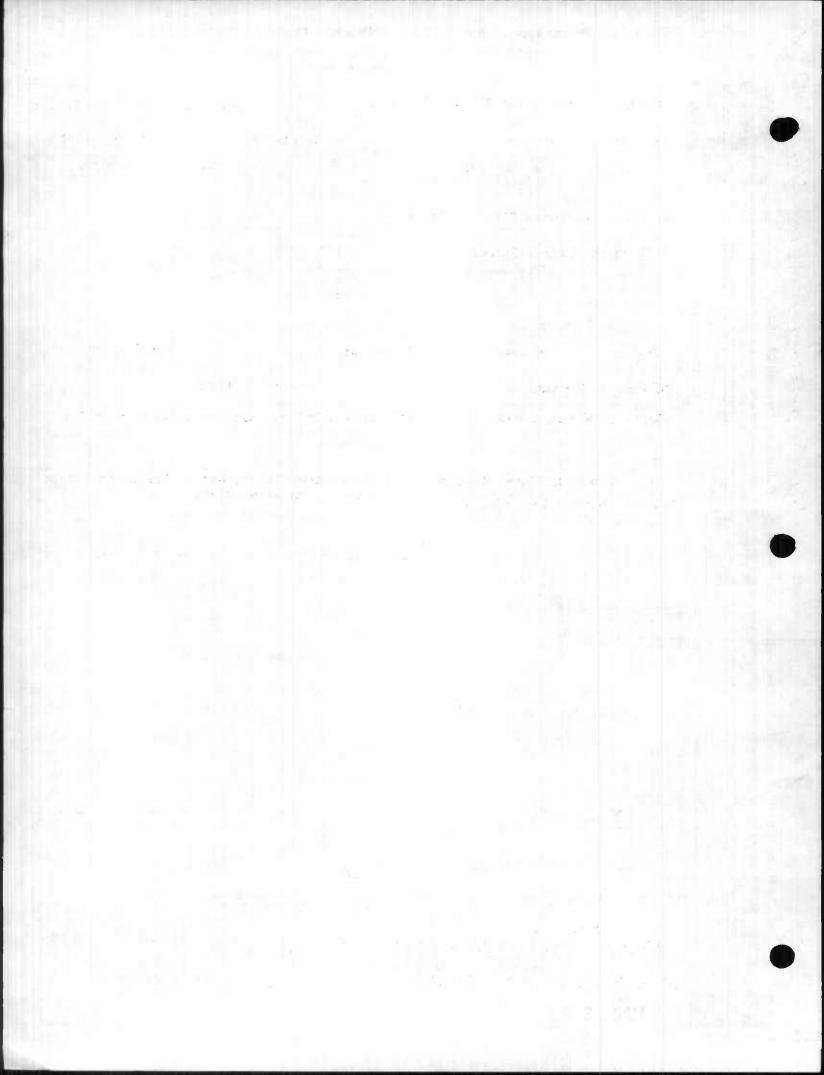
Registrar

MAR 1 8 1999





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Wilson J. Wiseman AKA Willson J. Wiseman March 6, 1999 12:30 AM /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Baltimore City Hospice at Gilchrist Baltimore 8. Date of Birth (Month, Dey, Year) If Under 1 Year | if Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Deys Hours 1 M 2 □ F 220-18-8321 72 Yrs. 1926 Maryland **Director** April 1, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Item 27 is marked other than "natural", or items 23s or 25s-f show other traumstic avent, the Medical Exeminer must be nothed at 1 XYes 2 No Baltimore Baltimore City Directo Maryland semm, Willson 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6601 North Charles Street 21204 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 1 ဩYas 2 ☐ No If Yes, Giva Yeer or Dates: 1 Never Merried 2 Married Specify: White 1 ☐ Yes 2 ☑ No Specify þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16h Kind of Business/Industry 2 should be filed within end Mental Hygiene. Elamantary/Secondary (0-12) Collage (1-4or 5+) Gas Station unknown Attendant unknown 18. Mother's Name (First, Middle, Melden Sumeme) 17. Fether's Neme (First, Middle, Last) Marie C. Frank Willson G. Wiseman 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Important: If them 27 is any injury or other traun 8308 Nunley Drive, Baltimore, Maryland 21234 Doris L. Wiseman/wife 20b. Pleca of Disposition (Name of cametery, cremetory or other pleca) 20c. Location - City or Town, Stete 20e. Method of Disposition Peges 1 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ Removel from State 4 ☑ Donetion 5 ☐ Other (Specify) monard Somwade, Director State MANGE Of Board, 655 W. Baltimore Street Baltimore, Maryland 21201 23e. P. rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, stock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Ancrentic Concer Examiner Dua to (or es e consequance of) Physician/Medical Examiner attending physician end for use as the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of): Box 68760 Due to (or as e consequence of) Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. myelo dysplasia 1 Yee 2 No 3 Probably 4 Unknown signed t by 24b. Wara autopsy findings eveilable prior to 24a. Was an autopsy completion of cause of death? certificate hes t lirector, page 2 s 1 ☐ Yes 2 No 1 Yes 2 No 25. Wes case refarred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospite 10 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Date of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 27 Menner of Death 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation s efter des. 1 Naturel 1 TYes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Pieca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide ò 24 hours 1 Certifying Physician: To the best of my knowledga, death occurred et the tima, data and piece, end due to the ceuse(s) end manner as stated.
2 Medicat Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred et the time, date end placa, and due to the ceuse(s) and mennar states. To the Hosp within 24 hot To the Fune completely fi edical (Check only one) 29d. Date signed (Month, Day, Yeer) 29b. Signeture and title of partille 29c. License number March 10, 1999 30. Name and address of person who completed use of death (Item 23e) (Type, Print) BALTO, Md 20204 A. Kiley 6-BIM N. Charles 6701 31. Dete filed (Month, Day, Year) Registrer's Signeture MAR 1 8 1999 Registrar **DHMH 16 Rev 6/95**



State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** Frank Martin Antonovich 4. 1999 4c. County of Death 1934 March /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 0-91-415 #72 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 1**₩**M 2□ F 214-76-0357 Director February 6,1947 Maryland Usual Residenca of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. inside City Limits other traumetic event, the Medical Examiner must be notified at Maryland Wicomico Director Mardela Springs 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 11351 San Domingo Road 21837 United States items 23e 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Race - American indian Black, White, etc. be filed within 72 hours efter 1 ■ Never Married 2 Married ☐ Yes 2 No Yes, Give 0 Maryland 21215-0020 1 ☐ Yes 2 B No Specify: P Specify: 3 ☐ Widowed 4 ☐ Divorced White "naturel", Year or Dates: Antonovich Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) Cotlege (1-4or 5+) n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Antonovich Eileen Dolorese Zhan 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) - 69 Peges 1 and 2 s ment of Health an permit. Peges 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra James Antonovich, Brother 728 Glen Eagles Dr., Fort Washington, MD 20744 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State Holy Face Cemetery 3-9-99 Great Mills, Maryland 4 Donetion 5 Other (Specify) 21. Signature of Funeral Seption Lie 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinst eld, Jr., M00052 22955 Hollywood Rd., Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. **Physician** tmmediete Cause (Finat disease or condition resulting in death) /Medical Henrica Examiner Due to (or as a consequence of): Examiner munon Folk The law requires that the death certificete be executed buriel-transi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Box 68760. attending physician esopho we Physician/Medical for use as P.O. Part il. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? been signed by should be detect 20 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings evailable prior to Completed 24a. Was an autopsy completion of cause of death? certificate has 1 Yes or Attending Physician: 25. Wes case referred to medicat examiner? Be 26. Place of Deeth (Check only one) Hospitet: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 Yes Napatient 2 ER/Outpatient 3 DOA After this Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. injury et Work? 5 Pending Investigation 1 Natural deeth. 1 Yes 2 No **€** □ Accident within 24 hours after deet To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) end manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and pleca, and due to the cause(s) end manner stated. 29a. Certifier (Check only

32. Registrar's Signature

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State Registrar 29b. Signature and title of certifier

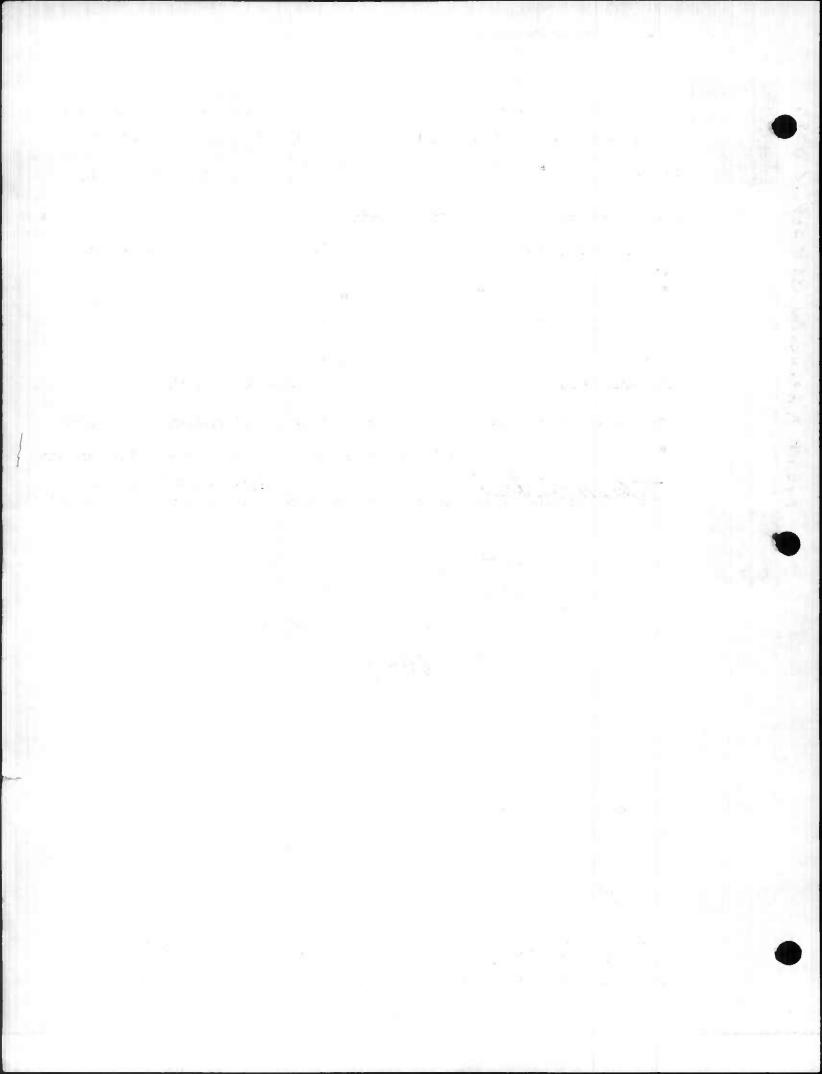
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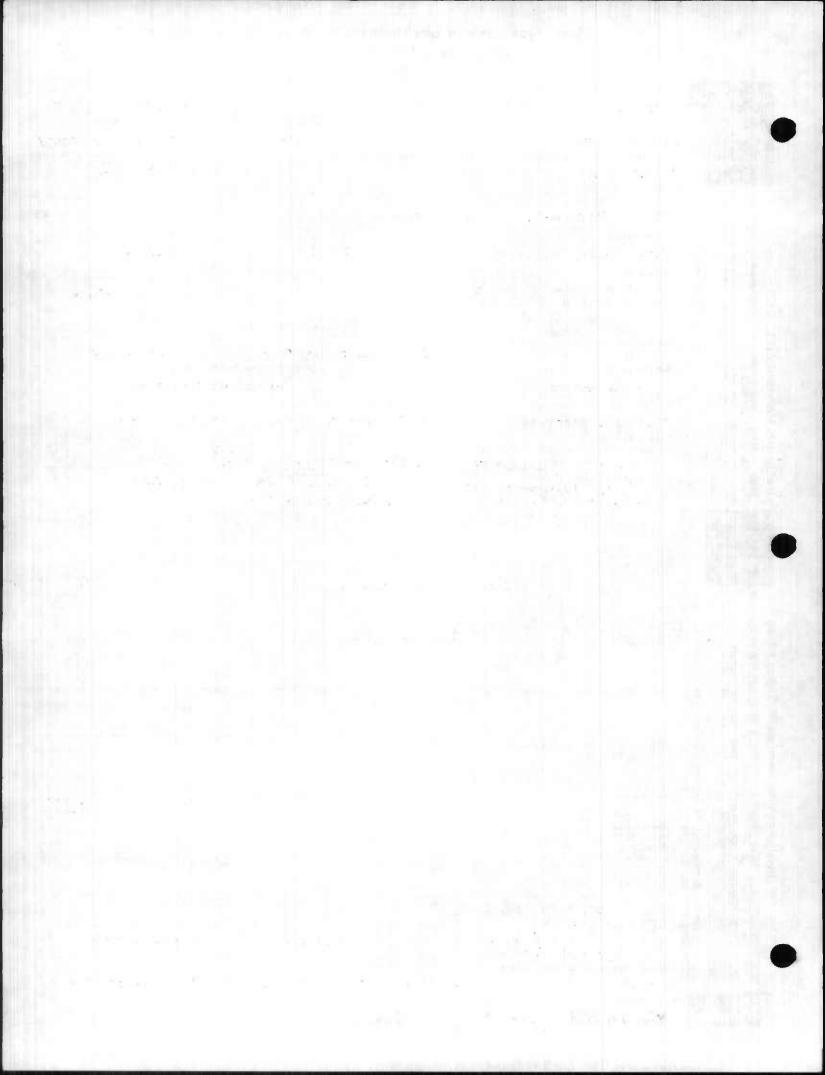


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State of Maryland / Department of Health and Mental Hygiene 9 08685

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	30. Name and address of person							,			1 0001	
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DHMH 16 Rav 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month 2:00 pm ANDREWS, SR. 1999 WILLIAM MCKINLEY MARCH 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth **MONTGOMERY** WASHINGTON ADVENTIST HOSPITAL TAKOMA If Under 1 Year | If Under 24 Hrs. Months Deys Hours Min. 8. Dale of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) Months 10XM 20 F 237-38-1102 11-1-1927 NORTH CAROLINA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits X□ Yes 2□No WASHINGTON 10f. Zip Code 10e. Street end Number 10g. Citizen of Whet Country? 606 ELMIRA STREET, SE 20032 U.S.A. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? TY Yes 2 No If Yes, Give 1961 Year or Dales: 10 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 1962 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th SECURITY N/A 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) DIXON POLLIE **ANDREWS** CHARLES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 606 ELMIRA ST., SE WASH.DC DOROTHY ANDREWS - WIFE 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stele 3-8 1 XBuriai 2 Cremetion 3 Removel Irom State QUANTICO NATIONAL CEM. 1999 4 Donetion 5 Other (Specify) TRIANGLE, VA, 21. Signetura of Funerel Service License 22. Name and Address of Fecility TAYLOR'S FUNERAL HOME 1722 NORTH CAPITOL ST., NW WASH. 23e. Pert1. Enler the disease, or complications that caused the death. Do not enler the mode of dying, such es cardiac or respiretory errest, shock, or heart leiture. List only one cause on each line. Approximele Intervei Between Onset end Deeth Immediate Ceuse (Final disease or condition resulting in death) 30 minule Sequentially list conditions, if any, leeding to immediate cause. Enler Underlying Cause (Disease or Injury Septecenna that initieted events resulting in death) Lest Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were eutopsy lindings evailable prior to completion of cause of deeth? 24e. Wes en autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dunpatient 2 ER/Outpalient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Slele

DC

Funeral

Director

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rai', or itema 23a or 28a-f ahov Examiner must be notified at

"natural", or itema

permit. Peges 1 and 2 should be filed within 7. Department of Haalth and Mentel Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Media once.

filed within 72 hours after

21215-0020

Baltimore, Maryland

68760

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Records.

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Division

Director

Funeral

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Completed

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Examiner Certification: To Be funeral

Physician/Medical þ Completed

certificate be executed After or Attending aftar deeth.

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To the Hospital o within 24 hours af To the Funeral D' completely filled it edicai State

Registrar

29b. Signature end title of certif

26a. Date of Injury (Month, Day Year)

29c. License number

28c. Injury el Work?

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated.

1 Yes 2 No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

AVE, TAKOMA PARK, MARYLAND 76 10 CARROLL MOBARAK

31. Dete filed (Month, Day, Year) MAR 0 4 1999

5 Pending investigation

6 ☐ Could not be

27. Menner of Death 1 Dinatural

2 Accident

3 ☐ Suicide

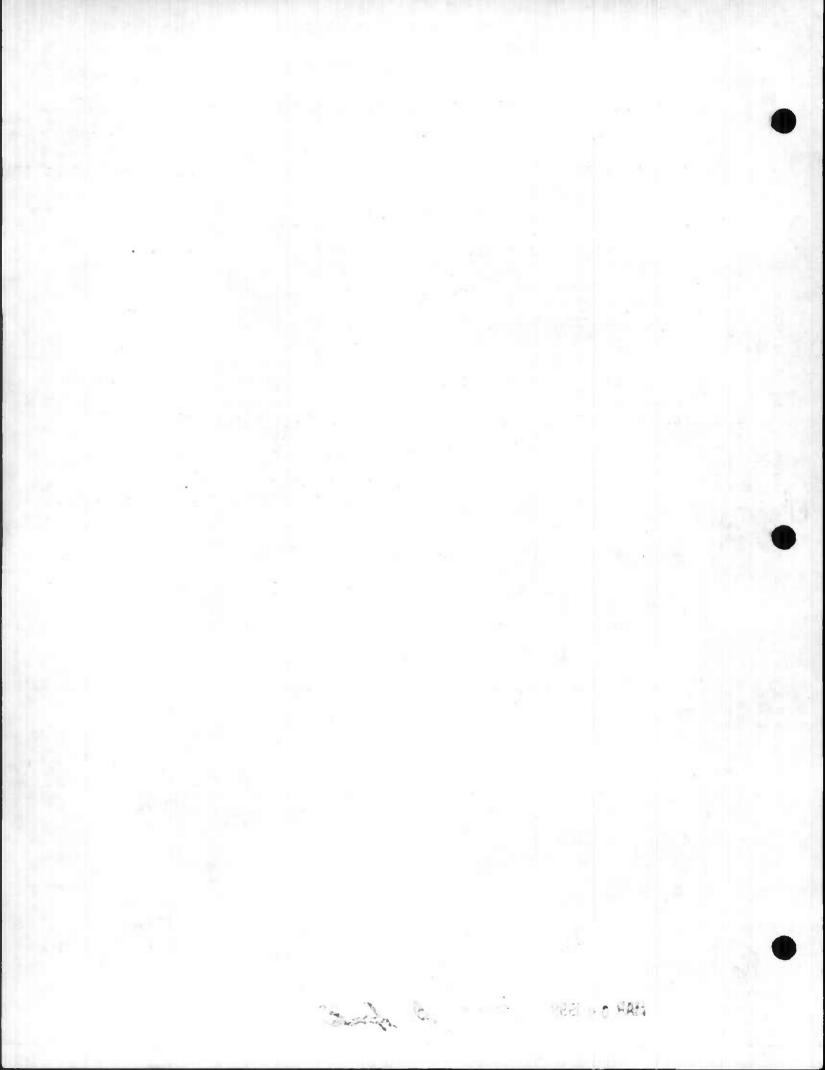
29a. Certifier (Check only one)

4 ☐ Homicide

32 Registrar's Signature

28b. Time of

28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)



Please Type or Print In Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 110 99 aM Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat MONTGOMER 141 8Ma 5. Sociel Security Number If Under 1 Yeer 24 Hrs. 9. Birthplace (Spate or Foreign Country) MON +GO Mer V 6. Sex 7. Age (In vrs. last birthdev) 8. Date of Birth (Month, Day. Months Deys Year) -32-80 Hours 1 M 2 W 5 8 Usuel Residenca of Decedant 10b. County 10c. City Town or Location 10d. Insida City Limits 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of Whet Country? 320 MONT 0 reen 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Meritel Stetus 14 Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced ack 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DQ NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) /Toma 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) NCOLN Informant's Neme/Reletionship (Type, Pnnt) SON 19b. Meiling Address (Street and Number . 8. St, 20002 ter 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20e. Mathod of Disposition 1 Burial 2 Cremation 3 Removel from State le N Wood 4 □ Donetion 5 □ Other (Specify) 21. Signature of Funerel Service Licenses 22. Name end Address of Fecility Bacon UNEra 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haart failura. List only one cause on aech lina. al Bat Immediate Ceuse (Finel disease or condition resulting In daeth) averion Myogardia Due to (or as a consequenca of): leusion Due to (or as e consequenca of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes casa referred to medical 26. Placa of Death (Check only ona) 3 DOA

Physician /Medical **Examiner**

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Physicien:

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Hospital

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within 24 hours after deet To the Funeral Director:

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completely

The lew requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records.

Physician

/Medical

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10a. Stete

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items 23a

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permit. Peges 1 and 2 should be filed within 72 ho Department of Heelth and Mentel Hygiene. Important: if them 27 is marked other than "nature eny Injury or other treumatic event, the Medical place.

the Maryland

72 hours after

Baltimore, Maryland 21215-0020

Physician/Medical Examiner Sequentielly list conditions, if any, leading to immediate cause. Entar Undarlying Ceuse (Disease or Injury that initiated evants rasulting in death) Last þ edical Certification: To Be Completed

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

1XYes 2□ No 27. Menner of Deett

2 Accident

3 Suicide

4 Homicida

1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Injury et Work? 1 Yas 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At home, ferm, street, factory, office building, atc. (Specify)

29a. Certifier (Check only

1 Certifying Physician: To the best of my knowledga, daeth occurred at tha tima, date end placa, end due to the cause(s) end manner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at tha tima, data and place, and dua to the cause(s) end menner steted.

29b. Signature and title of certifier 30. Name and eddress of person completed causa of deeth (Item 23e) (Type, Print)

5 Pending investigation

6 Could not be determined

29c. License number

29d. Date signed (Month, Dey, Year)

State Registrar

610 31. Dete filed (M nth, Dey, Year) MAR 0 4 1999

Carroll 32. Registrer's Signeture

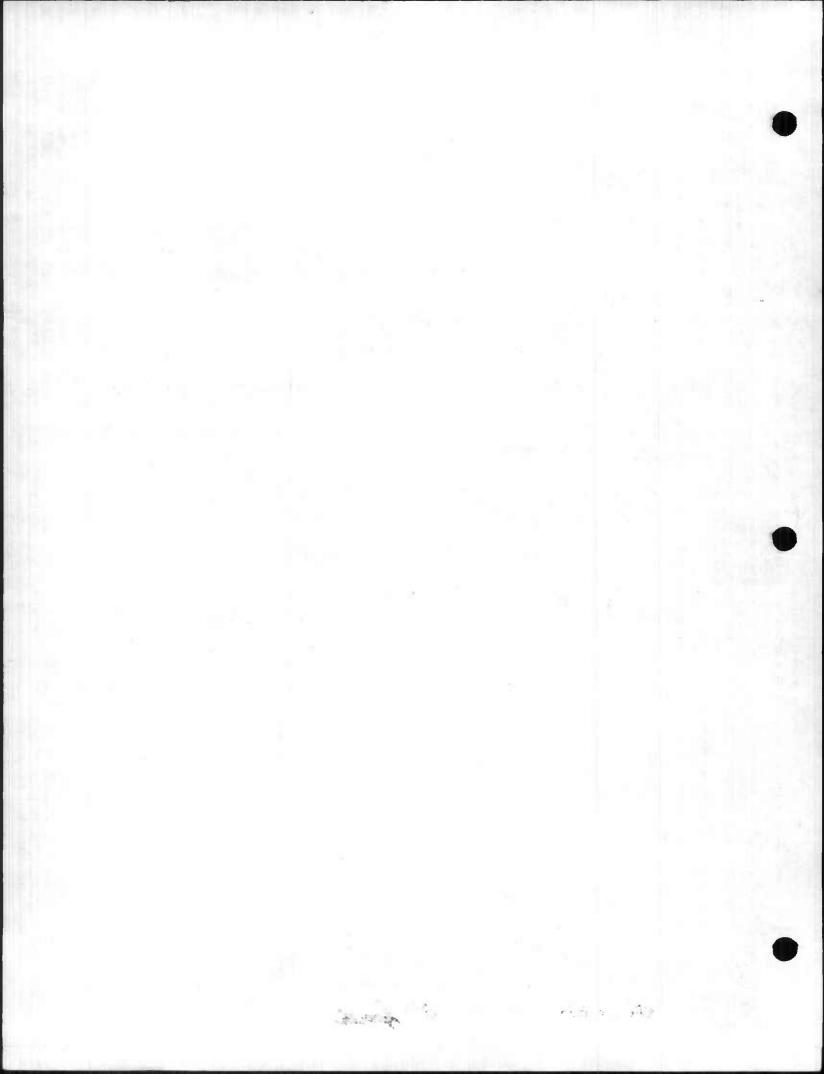
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Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Data of Death 3. Time of Death **Physician** GEORGE K. AINOOSON 02/ 28/ 1999 5:00 PM /Medical 4a Facility Nama (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** WASHINGTON ADVENTIST HOSPITAL Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs 6. Date of Birth (Month, Day, Year) 01/03/1950 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) **Funeral** Days ₩ 20 F Yrs. 49 Director Ghana, W Africa 212-45-9341 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1X Yas 2 No Director Maryland | Montgomery Silver Spring 10e. Street and Number 10g, Citizen of What Country? 10f. Zin Code 20903 Resident Alien/USA 108 C Ames Road Funeral 14. Raca - American Indian Bleck, White, etc. 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status be filed within 72 hours after of tal Hygiene. d other than "natural", or lien event, or Heder Exaction 1 ☐ Yes 2X No If Yes, Give Yaar or Datas: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2♥ No Specify: Specify: p 3 ☐ Widowed 4 ☐ Divorced African Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementery/Secondery (0-12) Financial Officer Accounting 17. Fathar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nort of Health end Mental 27 la marked o John Ainooson-Yaw 0 Elizabeth Quainoo 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 108 C Ames Road
Silver Spring, Maryland
20b. Plece of Disposition (Name of permit. Pages 1 and 2: Department of Health er Important: If Hem 27 is any injury or other trau Alfred Ainooson/Brother 20903 20e. Method of Disposition Dete 20c. Location - City or Town, Stete cemetery, cremetory or other plece) 1 XBuriel 2 Cramation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/19/99 Ghana, W. Africa Ghana Cemetery 22. Nama end Address of Fecility
Marshall's Funeral Home 21. Signature of Feperal Service Lie 4217 9th Street, NW Washington, DC 20011 23a Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner Sequentially list conditions, if any, leeding to immadiate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Box 68760. Physician/Medical Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? P.O. been signed by t should be detact 1 Yss 2 No 3 Probably 4 Unknown Records. Completed by 24b. Were autopsy findings available prior to 24e. Wes en autopsy performed? completion of causa of death? 2 No 1 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yas / 2 No 1 Inpatiant 2 ER/Outpetient 3 DOA this 28a. Deta of Injury (Month, Day Year) funeral 27. Menner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After or Attending 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No death. investigetion 2 Accident 4 hours after death 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a Medical 29e. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. To the 29c. License number 5 29d. Pate signed (Month, Day, Year)
March 01, 1999 29b. Signeture and title of certifier 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

Registrar

MOBARAK 31. Dete filed (Month, Day, Year) MAR 0 4 1999

76 10 CARROLL AVE, TAKOMA PARK, MARYLAM 82. Registrer's Signeture



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1 6 1	30. Nama and eddress of person w	no completed cale	e of death (Item	23a) (Type, Print))				

THEODORE MIKES

31. Date filed (Month, Day, Year)

MAR 0 2 1999

111 Penn Street, Baltimore, Maryland 21201

DHMH 16 Rev 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

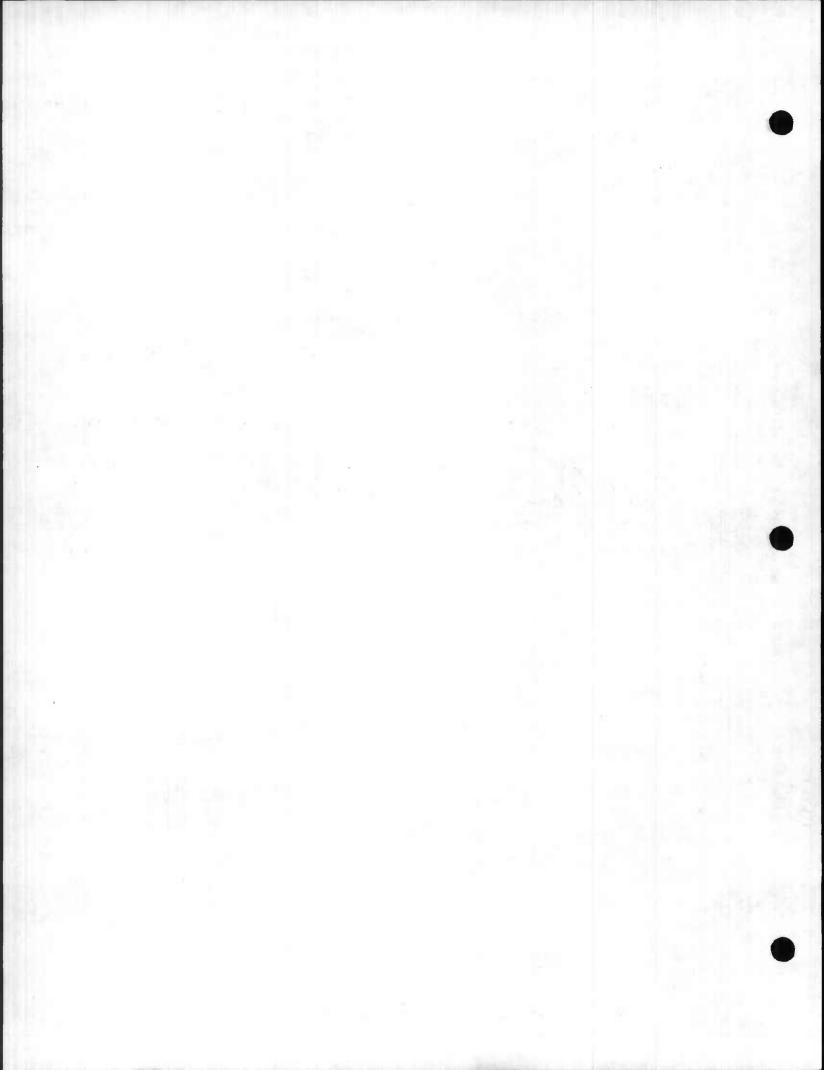
State of Maryland / Department of Health and Mental Hygiene.

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DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Year **Physician** 1545 **EVELYN** MARIE ATHEY March 1999 /Medical 4a Fecility Nema (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON 5. Social Sacurity Numbar If Under 1 Yaar | If Undar 24 Hrs. 6. Sax 8. Data of Birth (Month, Day, Year) APRIL 15, 1916 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 X F Yrs. 217-10-9573 82 Director MARYLAND Usual Rasidanca of Decedant 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow Examiner must be notified at 1 X Yas 2 □ No Director MARYLAND WASHINGTON **BOONSBORO** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Nema 23a 141 SOUTH MAIN STREET 21713 Funeral U.S.A. 12. Wes Decedant Evar in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indien, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: if them 27 Ia marked other than "natural", or Hen any Injury or other traumatic event, the Medical Exercises once. 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: 1 Nevar Marriad 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify. g Specify: 3 ☑ Widowed 4 ☐ Divorced WHITE Completed 16a. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highest grade complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) 12 Collega (1-4or 5+) HOMEMAKER OWN HOME 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Sumame) Be 0 RUSSELL L. HUTZELL CLARA SMITH 19a. Informant's Name/Ralationship (Type, Print) 19b. Maiting Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) CURTIS B. HANE/GRANDSON 9304 ADELAIDE DRIVE, BETHESDA, MARYLAND 20817 20b. Place of Disposition (Nema of cametary, cramatory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 3/6/99 KEEDYSVILLE, MARYLAND FAIRVIEW CEMETERY Signature of Funeral Service Loensee 22. Nama and Addrass of Facility 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or haert feiture. List only one cause on each tine. Approximata tntarval Batween Onset end Death **Physician** /Medical Immediata Ceusa (Final disaasa or condition rasulting in daath) prelemonea Examiner Dua to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Sequantielly list conditions, if any, leading to immadiate causa. Entar Undarlying Cause (Disaasa or injury that initiated events resulting in daath) Lest Due to (or as a consequence of): P.O. Box 68760, Due to (or es e consequance of): Part It. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been signed I should be det strome of Vital Records. à Completed 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of causa of daeth? 1 Yas 2 No 1 Yas 2 No certificate Attending Physician: director, 25. Wes casa ratarred to medical 8 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Dey Year) 27. Mangar of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of After Division Injury 5 Pending invastigation 1 Naturel death. 1 ☐ Yas 2 ☐ No 2 Accidant 24 hours after deal Funeral Director: 3 ☐ Suicide 6 ☐ Could not be datarmined 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicida ò Hospital 12 Certifying Physician: To the best of my knowledga, daath occurred at the time, data and placa, and dua to tha causa(s) and mannar as stated.
2 Medical Examiner: On tha basis of axamination and/or investigation, in my opinion, daath occurred at the tima, date and placa, and due to the ceuse(s) and mannar statad. Medical 29a. Cartifiar (Check only one) within 2 To the \$ 29b. Signeture and titla of certifier 29c. Licanse number 29d. Date signed (Month, Dey, Year) D32518 30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print) Suddnet 6eeting 00 31. Data filed (Month, Dey, Year) 32. Redistrar's Signetura State MAR 0 5 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	1. Decedent's Name (First, Middle,	(acf)			Pertifica				2. Date of De	Reg. No.	_	3. Time of Death
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/Medical	HELEN I.						44		Februar	-		0900
Examiner	4a Facility Nama (If not Institution,	give street end nu	m <i>ber)</i>				,		Location of Deeti		y of Death	
	Sinai Hospital					as 4 Van		timor		NONE		
uneral		6. Sex 1 □ M 3√2 F	7. Age (In yrs. I	ast birtho Yn	Month:	er 1 Year Deys				th ly, Year)	9. Birth	place (Stete or Foreig ntry)
ector	218-22-5496 Usuel Residence of Decedent	7.	90	110	s.				DEC. 1	6 1908	MAI	RYLAND
E ==	10a. State 10b. County		10c. City	, Town o	r Location							10d. Inside City Limits
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oner must be notified Funeral Director	10e. Street and Number				10f. 2	ip Code	A .			10g. Citizen of	What Cou	ntry?
ai D	96 CLAY STRE	ET				2140	01				US	
ner le	11. Maritel Status	12. Was Dec	edent Ever in U,S	6.	13. Was Dec	edent of	Hispanic	Origin? (S	Specify Yes or No to Rican, etc.)	- 14. Ra		can indien,
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To	WALTE	R DAVEN	PORT					IRE	WE FRIS	BY		
5	19a. Informant's Name/Relationsh								ural Route Numb			
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no or of	20a. Method of Disposition 1		State C6	metary.	isposition (A cramatory of	other pl		DEN	Date 2 / 1 / 0	20c. Location	,	
- Jery	4 Donation 5 Other (Sp. 21. Signature of Funeral Service L.	**	ATMIN	A P O I		EM. GARDENS 3/4/99 ANNAPOLIS, MD. and Address of Facility						LS, MD.
oud	21. Signature of Furieral Service L	Censee							IC MODE	TINDU	D 1	
	Lavy &.	Keese			WM.	KEE	DE C	S SOL	NS MORT	UARY,	P. A.	1-0.1
	23a. Part1. Enter the dilease, or c shock, or heart fillure. List o	complications that only one cause on o	caused the death each line.	. Do not	enterthe m	de or dy	ing, sac	h as cafdia	d of fespitatory a	meat, MD.	214	Interval Between
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er er	Immediate Cause (Final disease or condition resulting in death)	Asp:	iration	Pneu	monia							Days
	resulting in dealin)		Due to (or	as a cor	nsequence o	r):						
Examiner		b. Cong	gestive	Hear	t Fai	Lure					1	Years
dical Examir	Sequentially list conditions,		Dua to (or	as a cor	nsaquance o	j):						
E	Sequantially list conditions, if any, leading to immediata causa. Enter Undarlying Cause (Disaase or injury	. Нуре	ertensio	n							Y	ears
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Physician/M	Part II. Other significant condition	s contributing to d	eath but not resu	iting In th	ne underlying	cause g	jiven In P	Part I.	23b. Did	tobacco uae c	ontribute	to the cause of death
Phy									10	Yes 2000	3 Pro	obably 4 Unknow
should be datached leted by Physic											Tour W	lana and an ellana
etec									24a. Was	an autopsy ormed?	8	Vara autopsy findings vailable prior to omplation of cause
Comple											o	death?
Completed									1X	Yes 2□No	1	□Yes 2 No
Be	25. Was casa raferred to medical examiner?							Placa of De	ath (Check only	ona)		
on: To Be Co	10 Xes 2 No	Hospital:	Inpatient 2 E	R/Outpa	atient 3 I	NA		Nursing I	Home 5 ☐ Resi	dence 6 🗆 Ot	her (Spec	ify)
on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date (Mon	of Injury th, Dey Year)	28b. Tim Inju		28c. Inju	ury at		28d. Dascribe	how injury occu	irred	

Division of Vital Records, P.O. Box 68760, To the Hospital or Attendif within 24 hours after death. To the Funeral Director: Af completely filled in by the fu

Helen J. Barrett

Baltimore, Maryland 21215-0020

2 Accidant 3 Suicide

4 Homicide 29a. Cartifiar (Check only one)

6 Could not be datarmined

28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Steta)

1 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier

29c. License number P12307

29d. Date signed (Month, Dey, Year) February 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

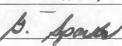
Sinai Hospital of Baltimore, 2401 W. Belvedere, Baltimore 21215 LK Bonasera, MD

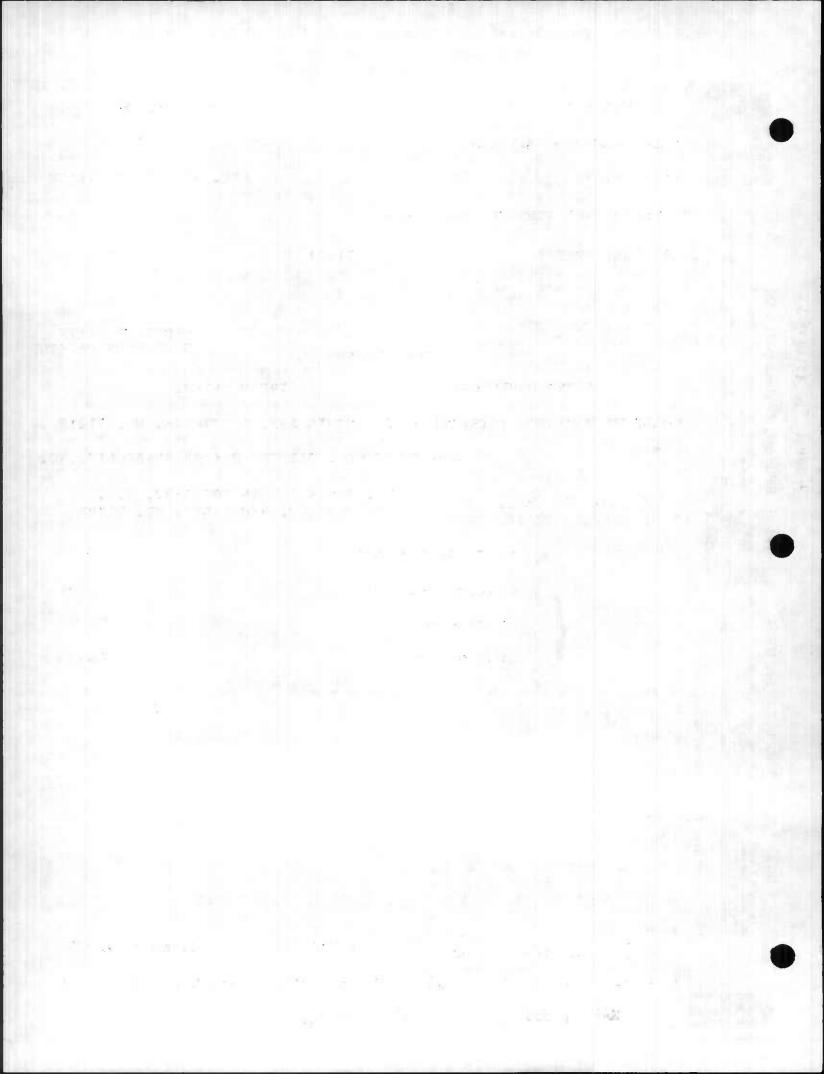
State Registrar

Medical Certificat

31. Date filed (Month, Dey, Yeer) MAR 0 4 1999







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) ^{Day} 1999 FEB. 24 6:45 am ELEANOR L. BLACKSTONE 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street end number) ANNE ARUNDEL ANNAPOLIS GENESIS ELDER CARE SPA CREEK if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) DEC . 19 1920 MARYLAND 9. Birthpiace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) Deys Months Hours 1 M 25 F 78 213-16-5566 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County MARYLAND ANNE ARUNDEL ANNAPOLIS 1 Yes 2 No 10f. Zip Code 21401 10g. Citizen of Whet Country? 10e. Street and Number 1910 D. COPELAND STREET US 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indien, 11 Marital Status Black, White, etc. 1 □ Never Married 2 □ Merried 1 Yes No Specify: Specify: BLACK 3 ₩idowed 4 Divorcad 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8th 18. Mother's Name (First, Middle, Malden Sumeme) 17. Fether's Name (First, Middle, Last) GOLDIE M. ALLEN ACTON ALLEN 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) 1628 SECRETARIAT DR. ANNAPOLIS, MD. 21401 CONNIE J. MORRIS (NEICE) 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burlel 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) ANNAPOLIS MEM. GARDENS 3/1/99 ANNAPOLIS,, 22. Name end Address of Facility 21. Signature of Funeral Servica Licenses WM. REESE & SONS MORTUARY, P.A. Javy J. Rese WII. REED ANNAPOLIS MD. 21401 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, Intervel Between Onset and Deeth Larry Kees fmmediate Ceuse (Finel disease or condition resulting in deeth) Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting In deeth) Last Due to (or es e consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24e. Wes en autopsy 1□ Yes 2 No 1 □ Yes 2 □ No 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Jursing Home 5 Residence 6 Other (Specify) 28b. Time of 28d. Describe how injury occurred

physicien and the buriel-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 88 use Por signed by the e hes pege 2 certificate director.

Examiner Physician/Medical by Completed Be 0 Certification:

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

? Is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

nit. Pagas 1 end 2 should be filed within 72 hours after or artment of Hauth and Mental thygiene. ortant: If fem 27 is marked other than "natural", or iter injury or other traumatic event, the Medical Examines.

permit. Page Department Important: If any injury or

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

with the Maryland

deeth

or Attanding Physician: After this funaral death. after death Director: filled in by Hospital 24 hours To the Hosp within 24 hou To the Fune completaly li

Registrar

Medicai

29a. Certifier (Check only one)

25. Was case referred to medical 1 Yes 25 No 28c. Injury et Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Neturel 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, date end pleca, and due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner stated.

29b. Signeture and title of

29c. License number

29d. Date signed (Month, Day, Year)

703 C

Charler, MJ 2/6/9

30. Name end eddress of p o completed cause of deeth (Item 23a) (Type, Print)

31. Dete filbd (Month, Day, Year)
MAR 0 1 1999 2108 32. Registrar's Signeture D. Dona's Drue

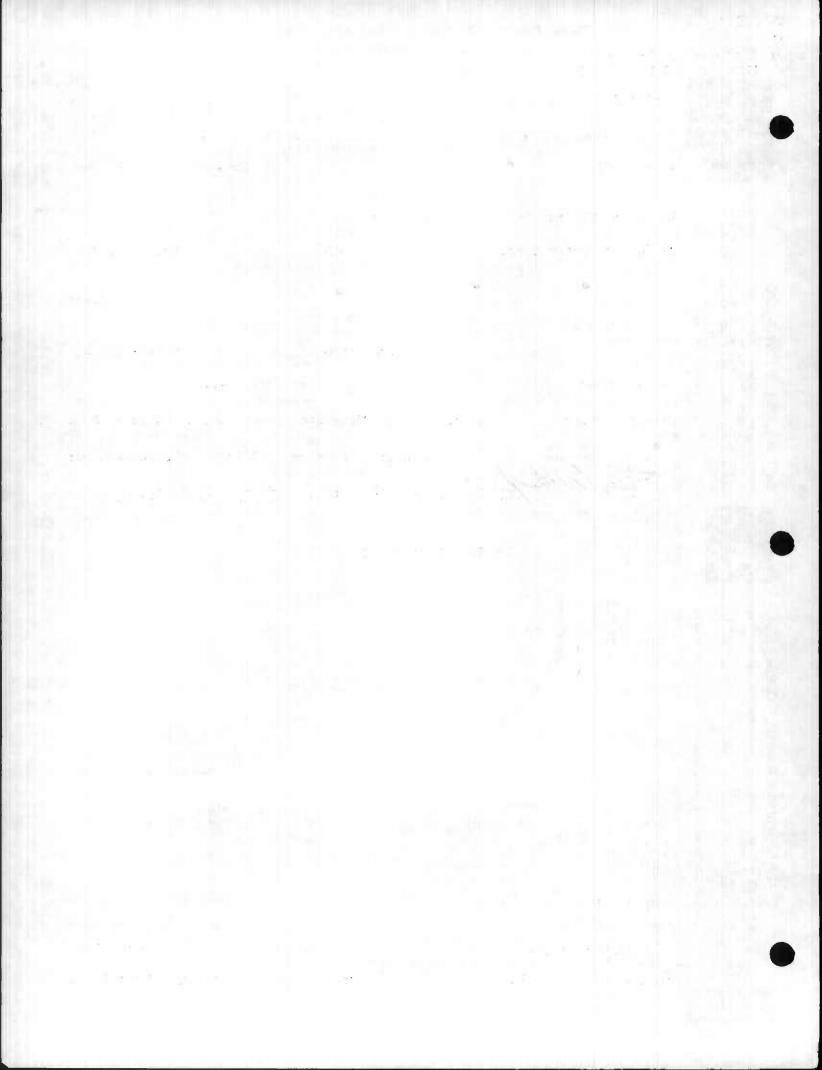
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Merial	Claud	ette	Bar	CIOW			State of	Maryla	nd / Department of Health and Men	ital Hygiene
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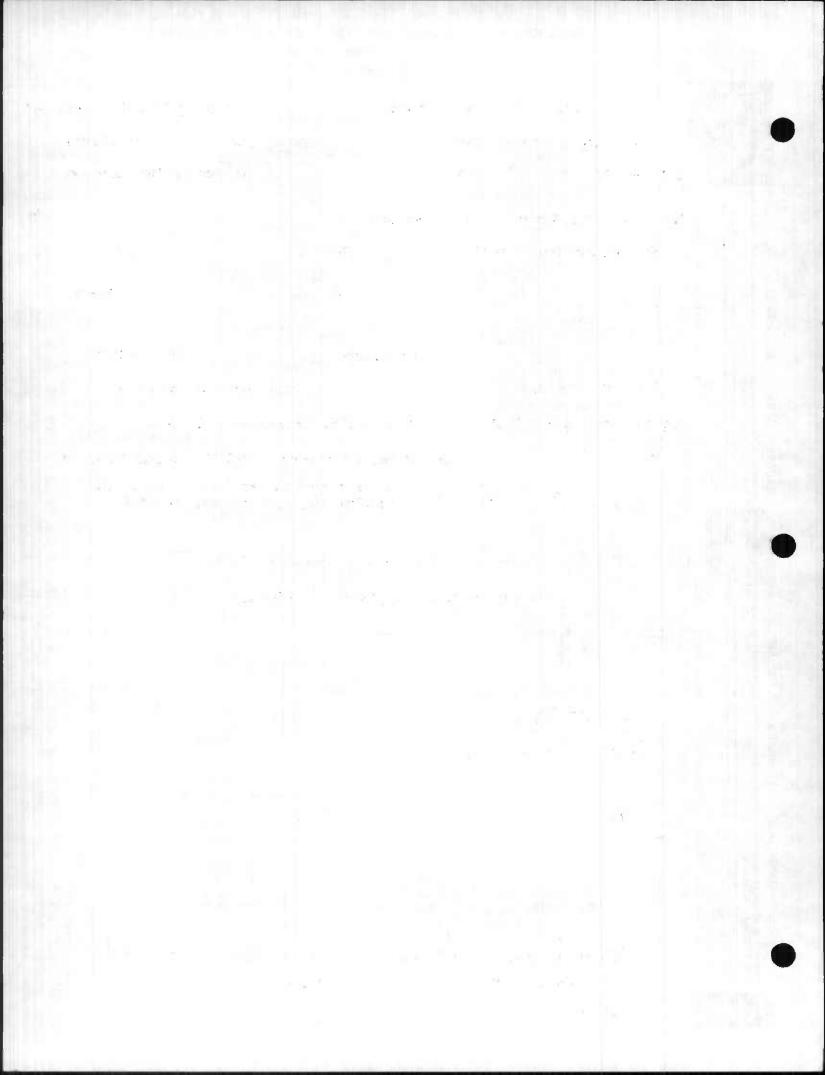
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Medical	4a Facility Name (If not institution, give s	treet and number)			4b. City, Town, or I		4c. County		10:50 A.M
aminer	22024 Gloucester C								
-	5. Social Security Number 6. Sex		est birthday) If Un	der 1 Year			St. M		(Stete or Foreign
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notified at	10a. State 10b. County		Town or Location						Inside City Limits
octo	Maryland St. Mary	r's Le	xington H						10 162 5 140
Dire	10e. Street and Number		10f.	Zip Code			10g. Citizen of V		
sunt.	22024 Gloucester (20653				State	
Examiner must be notified by Funeral Director	11. Meritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	I2. Wes Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates:			Hispenic Origin? (S en, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Specify	e - American II k, White, etc.	
b	15. Decedent's Educ		16a. Decedent's U	sual Occup	petion		16b. Kind of Bu	slness/Industr	y
Completed	(Specify only highest grede Elementary/Secondery (0-12)	College (1-4or 5+)	life. DO NO	work done Tuse retire	petion during most of world)	king			
E O	Lionidinary/obsolidary (o 12)	1	Super	vison	r		Retail	Sales	
Be C	17. Fether's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden Sumem	e)	
	James Cooper				Gertrude	Draytor	1		
-	19e. Informant's Name/Relationship (Type	oe, Print)	19b. Mailing Addr	ess (Street	t end Number or Ru			Stete, Zip Coo	de)
To	Gregory Barrow,	Husband	22024 G1	Ouces	ster Cour	t. Lexir	oton Pa	rk. MD	20653
	20a. Method of Disposition		aca of Disposition (/ metery, cremetory			Date	20c. Location -		
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	4 Donetion 5 Other (Specify)	7 /	eterans'		ess of Fecility	/12/99	Chelten	mam, M	aryland
once	Jack N'2	111				1 Home	P.A.		
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Ť.	4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	ne, iarm, street, fac	югу, опісе		City or Tow		er or noral no	ate manuel,
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Medi	290. Signature and the or certifier	nellare		0	CME	P	March 00	1000	
Medi	· Mayorte Or	nellfule	20a) (Trus. (D.)	0.	C.M.E.	ı	March 08	3, 1999)
completely filled in by tha funaral Medical Certification: 7	30. Name and address of person who co	nellall mpiotod sauso of deam (Hem Drift W	23a) (Type, Print)		C.M.E. Street, H				

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Funeral	5. Social Security		6. Sex	-	rs. last birthday)	If Under 1 Year	If Under 24 Hrs				ica (Stata or Foraigu
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or 28a-1 s be nounsed	Maryland		/ary's		Leonard	1				18.10.1	•
23a or 2			Church Ro	oad		10f. Zip Code 2065	0	1	0g. Citizen of V	U.S.A.	
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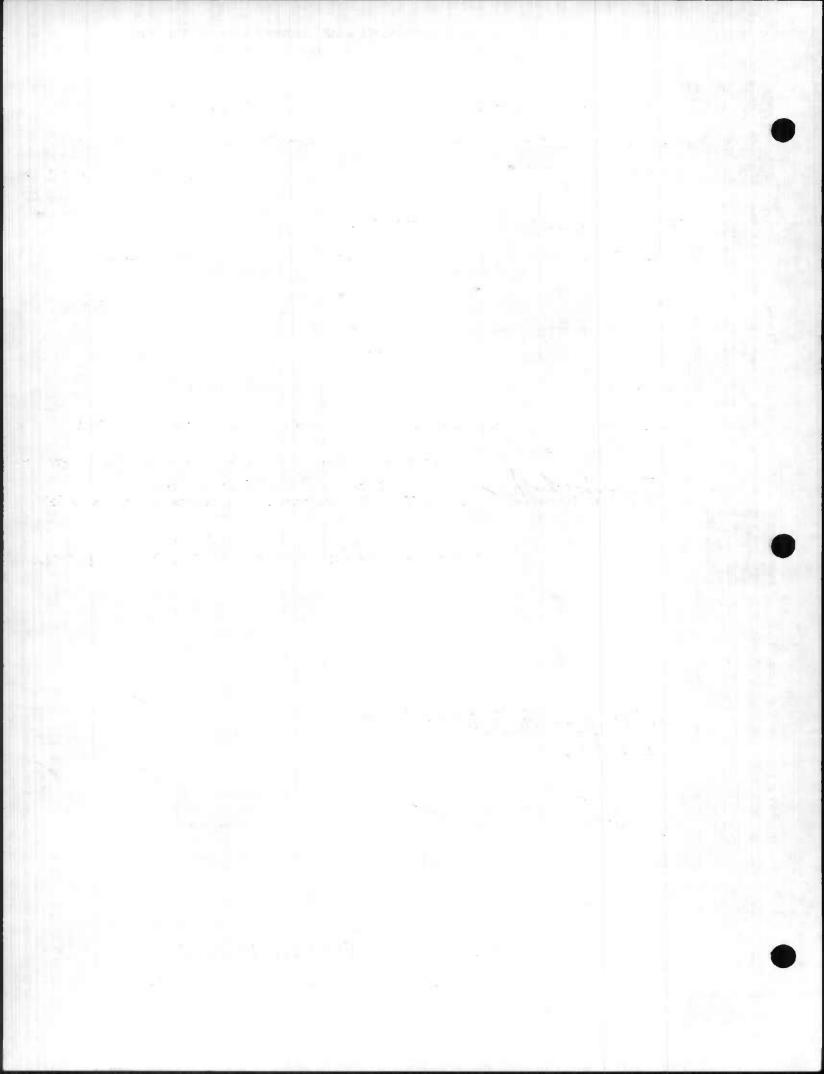
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** 2018 26, 1999 Vivian Roberta Baldwin February /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, giva street and number) 4c. County of Death **Examiner** Prince George's Malcolm Grow USAF Medical Center Camp Springs If Under 1 Yaar | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yaar) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** 1 M 2 B F Yrs. 237-28-2136 77 Director July 24, 1921 North Carolina Usual Residence of Decedent with the Marylen r 28a-f show 10a. Stata 10b. County 10c. City, Town or Location 10d, fnside City Limits 1 ☐ Yas 2 ■ No Director Maryland ST. Mary's Lexington Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pagas 1 and 2 should be filed within 72 hours aftar death with.
Department of Haalth end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 1 and injury or other traumatic event, the Medical Exerciter mant be no page. 21303 Baldwins Lane 20653 United States Funeral 14. Race - Amarican Indian, Black, White, etc. 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 ☐ Yas 2 ■ No If Yes, Give Year or Dates: 1 □ Nevar Married 2 □ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by 3 ■ Widowed 4 Divorced Black. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Housewife N/A 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Marvin Gross Elizabeth Rogers 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Intormant's Name/Relationship (Type, Print) Faith Thompson, Daughter 16981 St. Peter Claver Road, Ridge, MD 20680 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ■ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Glen View Cemetery 3/4/99 Durham, North Carolina 22. Name and Address of Facility
Brinsfield Funeral Home, P.A. Edward leld, Jr. N. Brinsi M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Pert1. Enter the disease, or completations that caused the death. Do not enter the moda of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** o Cardial infarction All reserves Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and s the buriel-trans Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Diseese or injury that initiated avents resulting in death) Last Due to (or as a consequenca of): daath certificata be axec Division of Vital Records, P.O. Box 68760, Physician/Medicai Dua to (or as a consequanca of): 98 usa ed by the a 23b. Did tobacco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed t py 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an eutopsy performed? page 2 s has 1 ☐ Yes 2 € No 1 Yes 2 No certificate or Attending Physician: funeral director, 86 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ inpatient 2 ☐ EF/Outpatient 3 ☐ DOA Certification: To After this 28a. Dete of fnjury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident s efter death 6 Could not be determined Location (Straet and Number or Rural Routa Number, City or Town, State) 3 Suicida 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 ☐ Homicide Hospital 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. Medical completaly (Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, snd due to the cause(s) and mannar stated. within 2 the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 Sam February 27,1999 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 7700 Old Branch Ave., #B-102, Clinton, MD 20735-1629 Sam Tellawi, M.D.

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year) MAR 0 2

32. Registrar's Signature



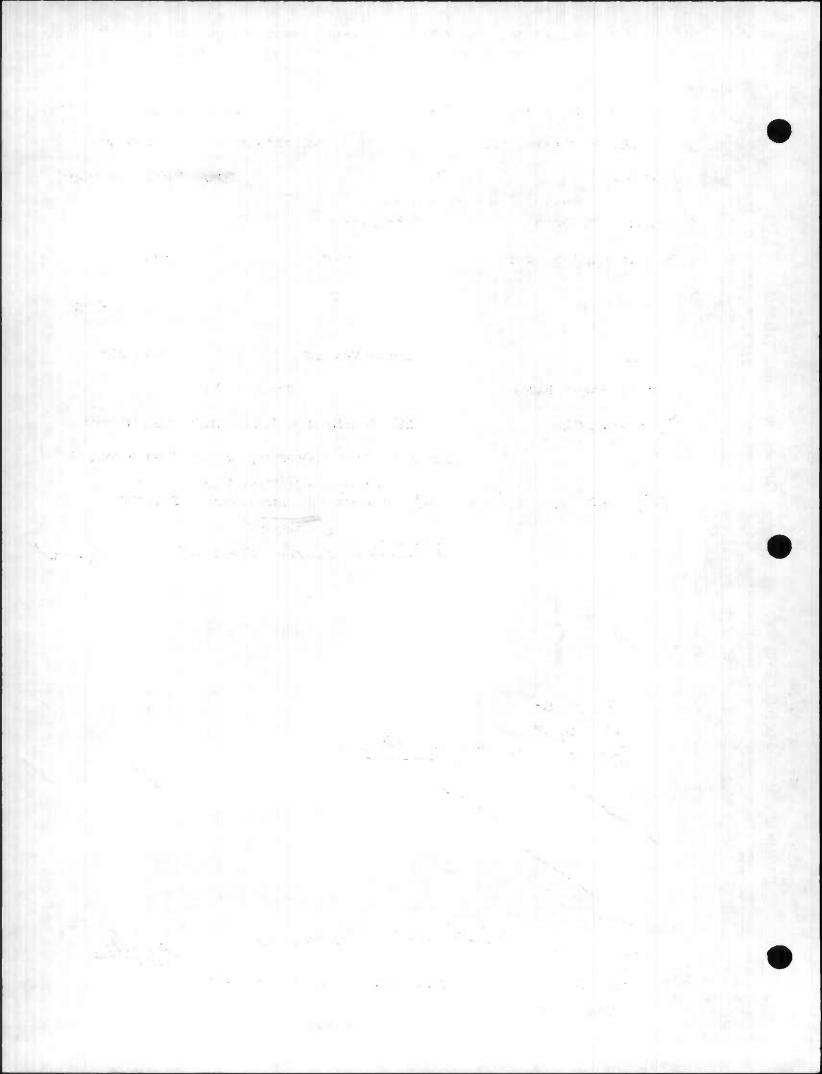
Funeral Director 5. Sociel Security Number 216-18-9974 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location Maryland St. Mary's 10f. Zip Code 10g. Citizen of 10g	y of Deeth Mary's 9. Birthplece (State or Foreig Country) Maryland 10d. Inside City Limit
/Medical Examiner 4e Facility Name (If not institution, give street and number) St. Mary's Hospital Funeral Director Joseph Herman Bowles March UI, 199 4b. City, Town, or Location of Death 4c. Count I Leonardtown St. Mary's Hospital Funeral Director St. Sociel Security Number 216-18-9974 Usuel Residence of Decedent Joseph Herman Bowles March UI, 199 4c. Count I Leonardtown St. Mary's Hours If Under 1 Year If Under 24 Hrs. (Month, Dey, Year) April 8, 1922	y of Deeth Mary's 9. Birthplece (State or Foreig Country) Maryland 10d. Inside City Limits
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Usuel Residence of Decedent	10d. Inside City Limit
10a. State 10b. County 10c. City, Town or Location Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of	
Maryland St. Mary's Mechanicsville Maryland St. Mary's Mechanicsville 106. Street end Number 106. Zip Code 109. Citizen of	4 D V 0 M 11
10e. Street end Number 10f. Zip Code 10g. Citizen of 20050 Novelo Condendary Docal	1 ☐ Yes 2 🖾 N
2000 North Condented Dock	Whet Country?
g 26850 North Sandgates Road 20659 U.S.A.	
26850 North Sandgates Road 20059 U.S.A. 11. Marital Status 12. Wes Decedent Ever in U.S. Armed Forces? 11. Never Married 2 (X) Married 12. Wes Decedent Ever in U.S. Armed Forces? 11. Never Married 2 (X) Married 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lif Yes, specify Cuben, Mexican, Puerlo Rican, etc.)	ce - American Indien, ck, White, etc.
1 Never Married 2 Married 1 Xyes 2 No If Yes, Give 1 Yes 2 No Specify: Specify:	v:
Specify: Spe	White
15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) Sth 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Building Contactor Constr.	susiness/Industry
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Elementery/Secondary (0-12) 5th 17. Fether's Neme (First, Middle, Last) Philip Temple Bowles Elementery/Secondary (0-12) Constructor Ruilding Contactor 18. Mother's Neme (First, Middle, Meiden Sume Elizabeth Burch	
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Philip Temple Bowles 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town	, Stete, Zip Code)
Tive Am Prilos Mife	MD 20659
20e. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location	- City or Town, Stete
1 XBuriel 2 Cremetion 3 Remove from State 4 Donetion 5 Other (Specify) 1 XBuriel 2 Cremetion 3 Remove from State 4 Donetion 5 Other (Specify) Maryland Veterans Cemetery 3/4/99 Chelt	enham, MD
	D A
21. Signeture of Funeral Service Licensee 22. Name, end Address of Fecility. Mattingley—Gardiner Funeral Home P. O. Beyr, 270. I separation.	
23a. Pert 1. Enter the disease, or complications that caused the data Po not enter the mode of dying-such as faudiac or respiratory errest.	Approximete
23a. Pert1. Enter the disease, or complications that caused the disease on each line. Physician	Interval Between Onset end Deeth
/Medical immediate Ceuse (Fine)	land
disease or condition resulting in deeth) e. Due to (or es e consequence of):	1 gra c
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d	
Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use c	ontributa to the causa of death
Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use c	3 □ Probably 4 □ Onknow
58 6 (1/1/2011)	24h Ware autonou findings
24e. Wes an eutopsy performed?	24b. Were autopsy findings aveileble prior to completion of cause
20 0	of death?
1 □ Yes 2 □ No	1 Yes 2 No
25. Wes case referred to adical examiner? 1 Yes 2 URo 25. Wes case referred to adical examiner? 1 Yes 2 URo 26. Place of Deeth (Check only one) Contact Check only o	
To tient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Or	
27. Menner of Deeth 28e. Dete of Injury 28b. Time of 28c. Injury et Work? 1 Describe how injury occumulation 28c. Injury et Work? 1 Yes 2 No	red
a c a 2 L Accident areasington	her or Rurel Route Number
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)	or or rigid riodic runnor,
29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and my knowledge, death occurred at the time, date and piece, and due to the cause(s) and my knowledge.	anner se etated
29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and my opinion, death occurred at the time, date and plece and menner stated.	
	gei (Mgfith, Day, Year)
1 bul M. Jale 110 754188 21	3/99
30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)	/
Dr. David M. Federle Philip J. Bean Medical Center, Hollywood, Mc	1. 20636

State Registrar 31. Dete filed (Month, Day, Year) MAR 0 4 1999

32. Registrer's Signeture

B. Sparker

JOSEPH HERMAN BOWLES



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Dhuniaian	#23 PART I, 27 PER ME 1. Decedent's Name (First, Middle TANT)	e, Last)		Certific	210 01		2. Date of Dea	Reg. No/ - ath Dey	Year	3. Time of Death		
Physician /Medical	1		r)			4b. City, Town, or	MARCH	9, 1999		1249 P		
Examiner	PRINCE GEORGES					CHEVER		PRIN	ICE GI	EORGES		
Funeral Director	5. Social Security Number 577-68-2091 Usual Residence of Decedent	6. Sex 1 □ M 2 F 7. /	49	est birthday) If U Yrs. Mon	nder 1 Year ths Deys		(Month, De	h y, Year) 6, 1949		lece (State or Forei		
ahow	10a. State 10b. County		10c. City	, Town or Location			10d. Inside City Limits					
the Meryle	District of Colu	mbia		Washing		DC			1 1 Yes 2 □ N			
uth with the Maryland 23a or 28a-f ahow unt be notified at	10e. Street end Number 3145 Newton St	., NE	10f. Zip Code 20018				10g. Citizen of What Co USA			itry?		
Maryjaffic 1.2.15-0020 d 2 should be filed within 72 hours after deeth th and Mental Hygiane. 77 is marked other than "naturel", or items 23 treumatic event, the Medical Examiner rount To Be Completed by Funeral	District of Columber 3145 Newton St 11. Meritel Stetus 1 Never Merried 2 Mar 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 Yes 2 fi f Yes, Give Year or Dates	med Forces? If Yes, specify Cuben, Mexicen, Puer Yes 2 ☑ No /es, Give 1 ☐ Yes 2 ☑ No Specify: ar or Dates:				pecify Yes or No o Ricen, etc.)		e - Americ ck, White, v: B1ac	etc.		
I Z I Z I D-UUZ. ed within 72 hours or ygiene. her than *naturel*, or it, it is Medical Exa	15. Decedar (Specify only highe	t's Education st grede completed)		16e. Decedent's (Give kind o	f work done	during most of wo	rking	16b. Kind of Bu	usiness/Inc	dustry		
withir than	Elamantary/Secondary (0-12)	Collage (1-4o	r 5+)	DISAL	Tusa ratire	ia)		NONE				
be filed tal Hyging dother event, Be Co	17. Fether's Name (First, Middle,	Last)		DISA	الاجادار	18. Mother's Ner	ne (First, Middle,		ne)			
in yianna should be filed of Mental Hyg marked other matic event,		on				Gra	ce Ann J	ohnson				
Mar 12 sh h and 'Is m	19e. Informent's Name/Reletions			19b. Mailing Add	ress (Streat	t and Number or Ru	ural Routa Numbe	er, City or Town,	Stete, Zip	Code)		
GOTE, MET ges 1 end 2 sh to of Health and If item 27 is m or other treum	Andrea L. Bake	r/daughter	20b. PI	3145 Nev	ton S	t., NE	Wash., D	C 20 20c. Location -	018 City or To	wn, State		
Z = Z = Z	Buriel 2 Cremation 4 Donetion 5 Other	3 Removel from Stat	8	imetery, crematory Glenwood		ice)	03/15/99					
Dallinore, n permit. Pages 1 end Department of Health important: if Item 27 any Injury or other 1 ange.	21. Signeture of Funerel Service	1	74	22. Nem	e end Addre	ess of Facility	LATNEY'S	FUNER	AL HO	ME, INC.		
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vrequires that the death cerverent signed by the attending should be detached for use letted by Physician/N		To double to double	50111011000	and in the street,		TOTAL TOTAL				bably 4 Unkno		
To Attending Physician: The law requires that the death cert after death. In the factor of the certificate hes been signed by the attending in by the funeral director, page 2 should be detached for use ertification: To Be Completed by Physician/M								en eutopsy med?	av	ara eutopsy findings alleble prior to mpletion of ceuse daath?		
vital nec							vz.	Yes 2□No	10	Yes 2□ No		
Physician: this certific ral director,	examiner?	Hospital:	127	7	Ot	hor	ath (Check only o					
ding Physic h. After this of funeral dire tion: To		28e. Dete of Ir (Month, L				28c. Injury at Work? 28d. D		5 Residence 6 Other (Specify) d. Describe how injury occurred				
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To the Hospital within 24 hours to the Funeral completely filled	29a. Cartifiar (Check only one)	g Physician: To the bes Examiner: On the besis end menner	of examinati									
To the comp	29b. Signature and title of certifie	helful	e		29c. Licen	.M.E.		29d. Date signe MARCH				
1 30	30. Name and address of person	who completed ceuse of Konfu	deeth (Item	23e) (Type, Print) Penn Str	eet,	Baltimore	e, Maryl	and 2120	01			
	31. Date filed (Mohth, Dev. Year)	32. Regis	trer's Signat	ure								

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State of Maryland / Department of Health and Mental Hygiene 9 9 8 7 0 0

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/sician	-	E	DITH S	J. BER	RRY				February	Day	Year 1999	10:48 AN
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12	-	10a. Stata	10b. County		100	c. City, Town or Lo	ocation				10d.	Inside City Limits
ral Director	5 1	MARYLAND	PRINCI	E GEORG	E'S	LANDO	VER					Y□ Yas 2□No
Director	3	10e. Street and Nu	mber				10f. Zip Coda		-	10g. Citizan of	What Country	?
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by Funeral	2	11. Marital Status 1 XNavar Mari 3 □ Widowed		lad 1 [2. Was Dacedant Evar in U,S. Armed Forcas? 1 □ Yas ② No If Yas, Siva Yaar or Datas: 13. Was Dacedant If Yas, specify 1 □ Yas 2 ☑			Hispanic Orlgin? (: ban, Mexican, Pua Specify:	Specify Yas or No- rto Rican, atc.)		ce - Amarican ck, Whita, atc y: BLACK	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 1. Decedant's Name (First, Middle, Last) 3. Time of Death February **Physician** LOUISE DELARA BUTLER 1999 11:55 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 24 Hrs. If Undar 1 Yaar 8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Country) 1913 Leesburg, VA 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** 10 M 2 F Months Days Hours 85 107-14-7746 Director Usual Rasidance of Dacedan the Maryland 10a, Stata 10c. City. Town or Location 10d. Insida City Limits 10b. County r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director Washington, D.C. 10f. Zip Coda 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with neat of Hatilh and Mental Hyglena. and If Item 27 is marked other than "naturel; or items 23s or Juy or other traumatic event, the Magical Example market. 1187 - 46th Place, S.E. 20019 U.S.A. Funeral 12. Was Dacedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarlcan Indian, 11. Marital Status Black, White, etc. 1 Navar Marriad 2 Marriad Black Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: p 3 Nidowed 4 Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work done during most of working lifa. DO NOT usa ratired) Elemantary/Secondary (0-12) Collaga (1-4or 5+) Domestic Worker Private 9th 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) Be Lucy Roberts William L. Jones 19b. Mailing Addrass (Street end Number or Rurel Routa Number, City or Town, Steta, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Bernard Butler/Son 1187-46th Place, S.E., Washington, D.C 20019 20b. Place of Disposition (Nama of cematary, cramatory or other place 20a. Method of Disposition 20c. Location - City or Town, Stata 03706 1 Burial 2 Cramation 3 Ramoval from Stata Department of Important: If any injury or once. Harmony Memorial Park Landover, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 1999 21. Signature of Funaral Sarvica Licansaa J. B. JENKINS FUNERAL HOME Per 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final HIVPotenper disaasa or condition rasulting in daath) Examiner rem of Examiner NOSTAGE physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiata cause. Entar Undarlying Cause (Disaase or injury that initiated avants rasulting in daath) Last Dua to (or as a consaquance of): Division of Vital Records, P.O. Box 68760 Physician/Medicai Dua to (or as a consequence of): attending p 88 OSleonyelis signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the ceuse of death? 1 Yee 2 No 3 Probably 4 Unknown by been sig 24b. Wara eutopsy findings available prior to complation of causa of daath? Completed 24a. Was an autopsy is certificate has director, page 2 1 Yas 2 No 1 TYas 2 No al or Attending Physician: The safter death.

I Director: After this certificated in by the funeral director, pages of in by the funeral director, pages. Be 25. Was casa refarred to medical 26. Place of Deeth (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Menger of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be daterminad 3 ☐ Suicida 28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) Location (Straat end Number or Rural Route Number, City or Town, Stata) 4 Homicida hours a 1 Certifying Phyaicien: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to the causa(s) end mennar es steled.

2 Medical Examinar: On tha basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steled. 29a Cartified Medicai To the Hot within 24 h To the Fur 29c. License number 29d. Data signad (Month, Day, Year) 29b. Signature and title of certifiar March 3, 1999 30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print) Khosrow Dauachi, M.D., 1328 Southern Avenue, #202, Washington, D.C. 20032 efiled (Month, Day, Year) 32 Registrar's Signatura

State Registrar 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death MARCH 1100 AM BARBARA BOONE ANN 4c. County of Death 1999 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth FORESTVILLE PRINCE GEORGES TRACY LANG 3000 H Under 24 Hrs. 8. Date of Birth (Month, Dev, Year) May 2, 194 If Under 1 Year 5. Sociel Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 1 □ M 2 🗡 F Months Days 58 220-34-8523 Yrs. Maryland Usual Residence of Deceden 10b. County 10c. City, Town or Location t 0d. Inside City Limits 1 Yes 2 □ No Maryland Prince George's Forestville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3000 Tracy Lane 20747 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 X No Specify: 3 ₺ Widowed 4 Divorced 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Private 11th 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nelson Harper Catherine Owens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Pnnt) Latrice Heyward/Daughter 926 Newington Court, Capitol Heights, MD 20743 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 93686 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State Resurrection Cemetery Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licenses J. B. JENKINS FUNERAL HOME Perce 7474 Landover Road, Landover, Maryland 20785 ancu 23e. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CONGESTIVE HEART FAILURE disease or condition resulting in deeth) Due to (or es a consequence of) CARDIOVASCULAR DISEASE ARTERIOSCUEROTIC Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably

Physician /Medical Examiner

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Division of Vital Records, P.O. Box 68760

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Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

24b. Were autopsy findings available prior to 24a. Was an autopsy completion of ceuse of death? 1 Yes 2 No 1 TYes 2 No 25. Was cese referred to medical 26. Place of Deeth (Check only one) Other: 4 □ Nursing Home 5 Residence 6 □ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State)

4 - Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29a. Certifier (Check only one) Certifying Phyalcian: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) and manner es stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

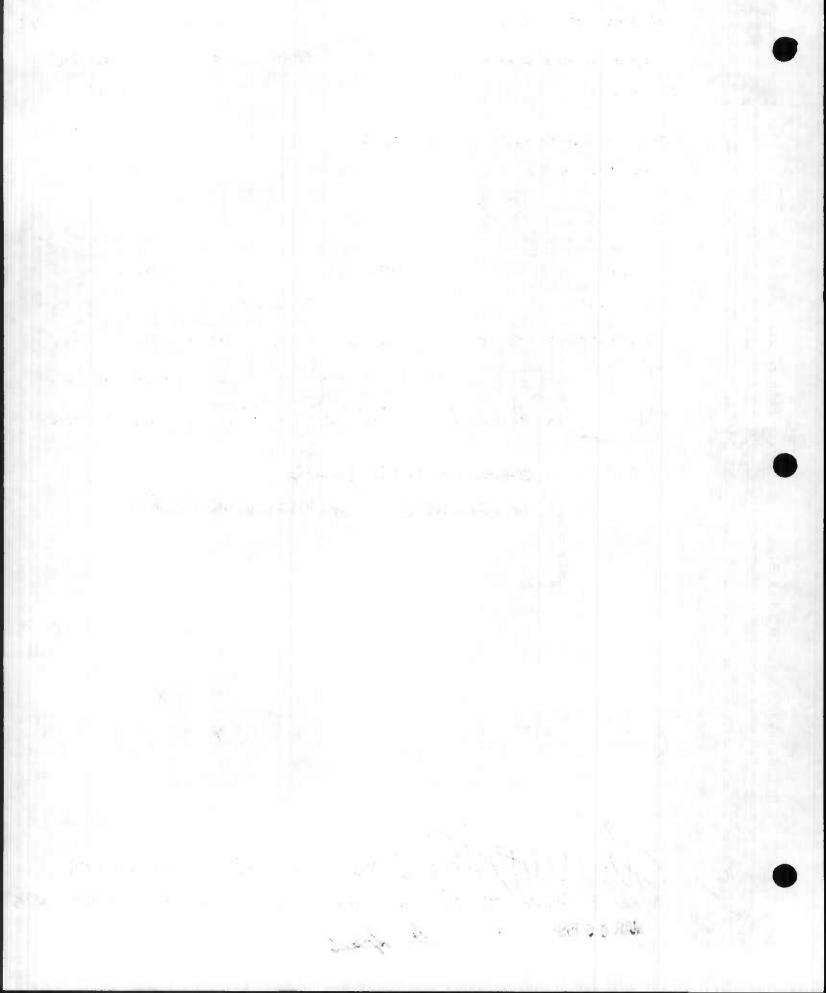
ause of death (It m 23a) (Type, Print) lress of person who comp

3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785 MD GOLLE JR MARIO

31. Dete filed (Manth, Dey, Year)
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32. Registrar's Signature

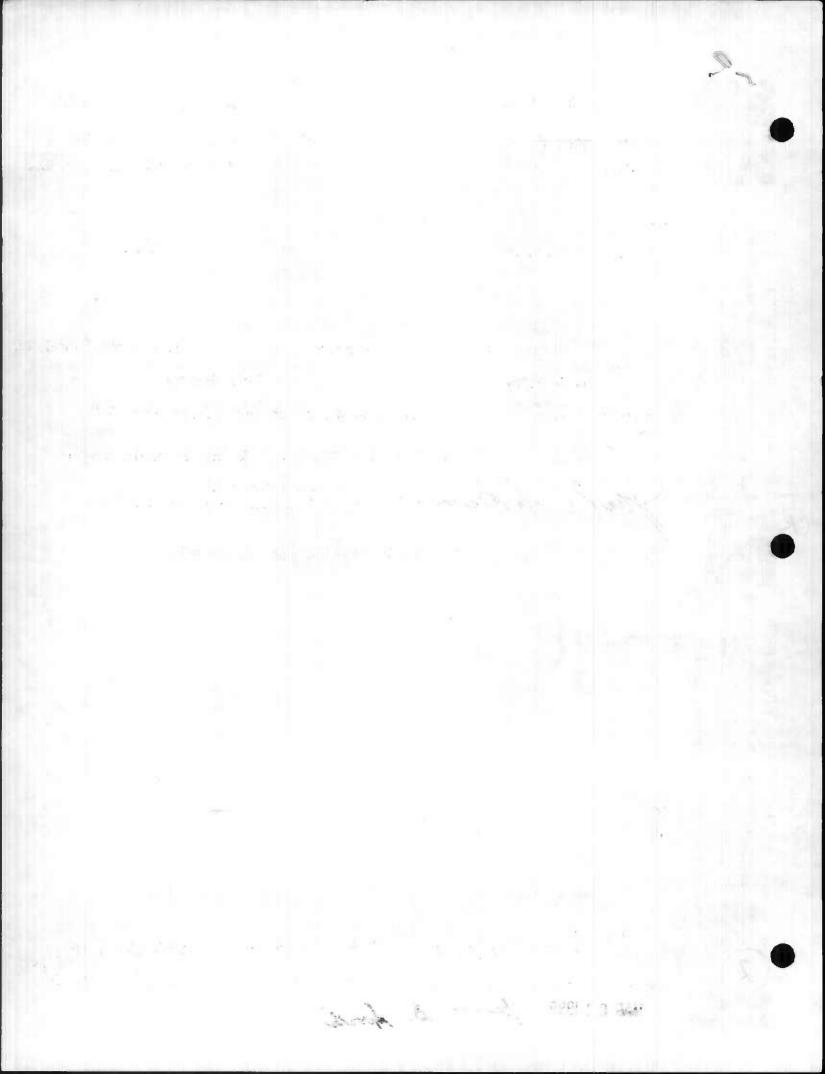
State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 08703 Certificate of Death Amend item #'s 4a.& 26.Per M.E.PGC 3-1-99 cr 1. Decedent's Neme (First, Middla, Last) 2. Date of Death 3. Tima of Death Month **Physician** 0019 Ronald Blakeney 1979 PEBRUARY 18 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner WASHINGTON ROAD PRINCE GEORGES FORT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth October 10 ear) 950 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foraign **Funeral** Months Deys Hours M 2□F Wastiffiction, D.C. 48 Yrs 578-68-5679 Director Usuat Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or Items 23a or 28a-f show adical Examiner must be notified at Yes 2 No Director Washington D.C. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20002 301 Seaton Place, N.E.#4 Funeral death 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, 11. Marital Status Black, White, atc 72 hours aftar XXNever Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0020 If Yes, Give Year or Dates: Specify: Specify: **Black** P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) The Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Hygiena. Ft. Washington Medical Ctr. Secretary 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Sumame) Be Pages 1 and 2 should be 1 nent of Health and Mental Eloise Blakeney Donald McLloyd 0 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 914 Palmer Road #1 Fort Washington, Maryland 20744 19a. Informent's Neme/Relationship (Type, Print) ROberta Walker (Sister) of Health I 20b. Place of Disposition (Nama of camatary, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 Coremation 3 ☐ Removal from State Chesapeake Crematory, Inc. 3/1/99 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee 22. Name end Address of Facility Rollins Funeral HOme, Inc. eese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, are List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical DEFICIENCY SYNDROME ACQUIRED IMMUNE Examiner Due to (or as a consequence of) Examiner physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of) ettending p signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 Unknown 1 Yes 2 No Division of Vital Records, à 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of ceuse of death? WE page 2 2 XN0 cartificate 1 Yas 2 No director. 25. Was cese referred to medical exeminer? Be 26. Place of Death (Check only one) RELATIVE"S HOME 1 Yes 2 No 27. Manner of Deeth Other: 4 Nursing Home 3 nesidence 6 Nother (Spec 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Yaar) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: Aftar 5 Pending Investigation Attending 1 Naturel efter deeth. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 6 A 24 hou. Hospital 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and menner es stated. To the Hosp within 24 hor To the Fune completaly fi (Check only one) 25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end piece, and due to the ceuse(s) and manner state. 29b. Signati 29c. License number 29d. Date signed (Month, Day, Year) DRIVE, MARIO 32. Registrar's Signature 31. Dete filed State Registrar

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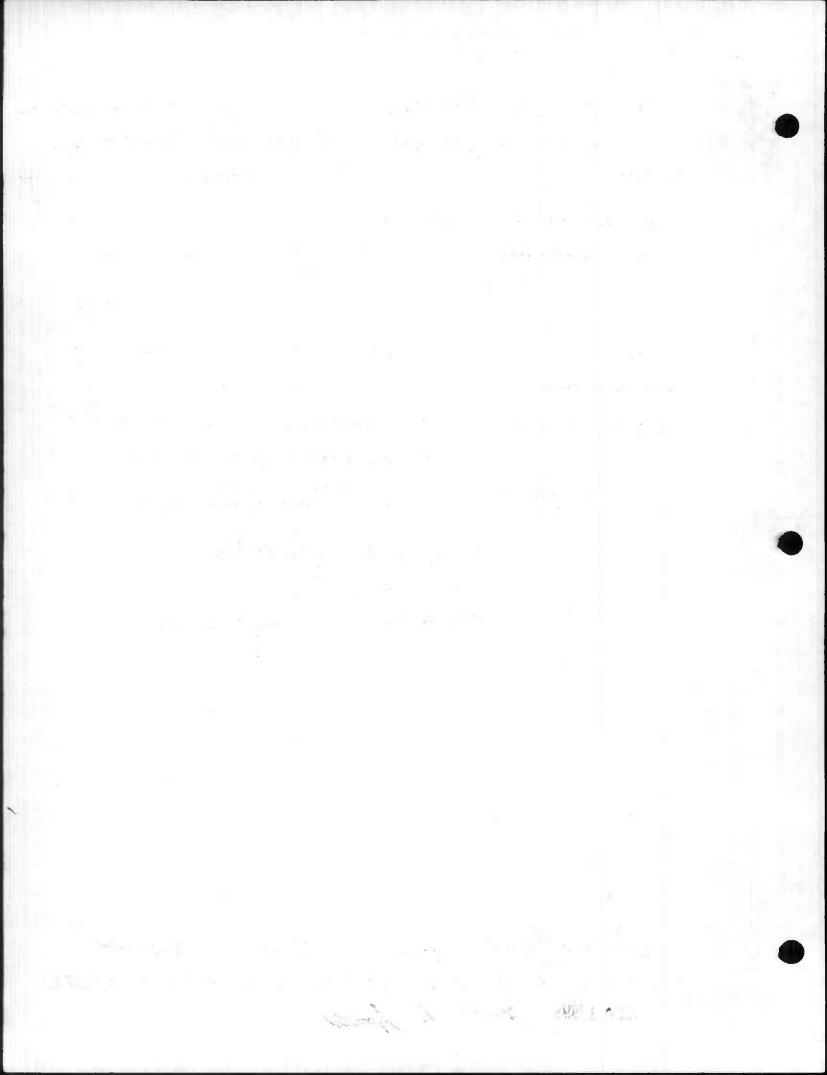


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State of Maryland / Department of Health and Mental Hygiene

		1. Decedent'e Name (First, Middle, L	.ast)					2. Date of D	eeth		3. Time of Death
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How		10a. Stete 10b. County		10c. City	, Town or Loca	ation			10d. Insida City		
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or 20	Director	10e. Street end Number				10f. Zip Cod			10g. Citizen of	Whet Count	ry?
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ury		4 □ Donetion 5 □ Other (Spec		Fo	rt Line	coln Cr	rematory	2-25-99	Brentwo	od, Ma	aryland
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DHMH 16 Rev 6/95



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Ateek	oa Begum		State of Maryla		nent of F cate of			giene Reg. No.	087	705
	Physician /Medical	1. Decedent's Name (First, Middle, Las AGEEBA	BEGUM				2. Data of De Month March	Day	Yaar	Time of Death 5:18 A.M.
	Examiner	4a Facility Name (II not institution, give New Hampshire Ave		ood		4b. City, Town, or L Silver Sp	oring	Mont	of Deeth	
	Funeral Director	UNKNOWN	ox 7. Age (In yr		Under 1 Yaar nths Days	Hours Min.	8. Date of Bir (Month, Da 3-5-3	th ly, Year) 30	9. Birthplaca Country) Pakis	(State or Foreign
	r 28a-f show	Usual Residence of Decedent	STREET, CO.	City, Town or Location		3			Insida City Limits	
	ther death with the Mei r flems 23e or 28e-f e recomment be notified Funeral Director	10e. Street and Number 15131 Fairlawi			of. Zip Coda			10g. Citizen of V		
020	filed within 72 hours efter death with the Meryland Mydiene. Mydi	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decadent Ever In Armed Forcas? 1 ☐ Yes 2 XNo If Yes, Give Yeer or Dates:	If Yes	Decedent of I	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No Rican, etc.)	14. Rac Blac	e - American lick, White, etc.	
21215-0020	led within 72 hot tygiene. Not the Medical of the	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de com <i>pleted)</i> College (1-4or 5+)		of work done OT use retire	during most of work d)	king	16b. Kind of B	usiness/Indust	у
		12 17. Father's Name (First, Middle, Last)		Home	emake	18. Mother's Nem	ne (First, Middle	HOM , Maiden Suman		
Maryland	should nd Men nd Men marke umarke	Dost Muhamma 19a. Informant's Name/Relationship (1)		19b. Mailing Ad	dress (Stree	Para t and Number or Ru			State, Zip Coo	de)
Baltimore, M	is 1 and if Health Item 27 other tr	Javaid Khan 20a. Method of Disposition 1 Burial 2 Cremation 3 Check Control of Contro	Removal from State	15131 I D. Placa of Disposition cometery, cremator George Wa		Silver Date 3-5-99	Sprin 20c. Location Adelph	City or Town,	20905 State	
Baltii	permit. Page Department of Important: If any Injury or pnce.	21. Signature of Funeral Service Licental August 21.	ary I	nc.						
Ch	Physician /Medical Examiner	23a. Part1. Enter the disease, or compshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	· Muche		fus	Ing, such as cardiac	or respiratory a	rrest,	Inte	proximate erval Between sat and Death
Box 68760,	Attending Physician: The law requires that the death certificate be executed stress. As death, and death certificate has been signed by the ettending physician end by the funeral director, page 2 should be deteched for use as the buriel-transit iffication: To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequenca of): C. Due to (or as a consequenca of): d								
P.O.	that the death certificated by the ettending produced for use expected for use expected by Physician/Me	Parl II. Other significant conditions of	ontributing to death but not r	resulting In the underl	ying cause gi	iven in Part I.	23b. Did tobacco use contribu			e cause of death?
of Vital Records,	cate has been signed page 2 should be d					s an autopsy ormed?	availat	autopsy findings ble prior to ation of cause th?		
Vital R	ysicien: The la s certificate he director, page To Be Com	25. Was case referred to medical examiner?	Hospital:	E EDIO Assetiant	G 504 0	26. Place of Dea	ath (Check only			at scene
Division of	ital or Attending Physics selected. To all Director: After this could in by the funeral director: Certification: To	1 Yes 2 No 27. Manner of Deeth 1 Natural 5 Pending 2 Accident Investigation 3 Suicida 6 Could not be 4 Homicide	28a. Dete of Injury (Month, Day Year, 3 3 9 9 28e. Placa of Injury - Al building, etc. (Spe	t home, farm, street, scify)	28c. Inju Wo	ry at ork? Yes 2 No	28d. Describe PEOES 28f. Location (City or To	how Injury occur TWAW (Street and Num. wn, State)	STULL STULL ber or Rural Ro	NHICLO LPY Dute Number, CO - MD
	To the Hospital or Att within 24 hours effer of To the Funerel Direct completely filled in by Medical Certifi	29a. Certifier 1 Cartifying Ph	ysician: To the best of my k niner: On the basis of exami and manner stated.	knowledge, death occination and/or Investi	urred at the t gation, in my	ime, date and placa opinion, death occu	and due to the	cause(s) and m	anner es state	OWT GOMENS ed. e cause(s)
	To the To the comple	29b. Signature and title of certifiar	ne Yhnele)		osa number O.C.M.E.		29d. Date signe March	03, 199	
	(3)	30. Name and address of person who	completed cause of death (I			Street, 1	Baltimo	re, Mary	land 2	1201

State Registrar

31. Date filed (Month, Day, Year)

MAR 0 4 1999

32. Registrar's S 32. Registrar's Signature

Telephone in Archive In 1997 to 1997 a The state of the s

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Nama (First Middle Lest) February 26 1999 **Physician** RAYMOND LEON BOONE, SR. 6:45 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) **Examiner** Clinton
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) Southern Maryland Hospital
Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Prince George's

9. Birthplace (Stete or Foreign Country) **Funeral** M 2□ F Months 577-20-1601 Yrs. Director 59 July 16,1939 Wash., D.C. Usual Residence of Decedent with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show TYPes 2 No Directo Maryland Prince George's Forestville 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours efter deeth with Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural; or items 23a or any injury or other traumatic event, the Medical Examiner must be a say injury or other traumatic event, the Medical Examiner must be a 1313 Woodlark Drive 20747 Funeral U.S.A. 12. Was Decedent Evar In U.S. Armed Forces? 1 ∰ Yes. 2 □ No Army If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16h Kind of Business/Industry Government. Elementary/Secondary (0-12) College (1-4or 5+) Printing Office 12th Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Charles Billings Dorothy Boone 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 20001 #1, Wash., D.C.
20c. Location - City or Town, State Keith Boone/Son 83 New York Avenue, Apt. 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 03/05 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from Stata Harmony Memorial Park 1999 Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Sarvice Licensee J. B. JENKINS FUNERAL HOME 20785 Tercen Vancu 7474 Landover Road, Landover, Maryland 23a. Part1. Enter the disease or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilur, stonly one cause on each line. Approximate Interval Between Onsat and Death **Physician** 1-typoten Sion. /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner END STAT NEW L certificata be axecuted physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) 88 nse 0 ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? signed by 3 Probably 4 Unknown 1 Yes 2 No by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed complation of causa of death? page 2 hes this certificate ! 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P L 1 npatiant 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Data of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28c. Injury at Work? 1 Naturel 5 Pending

Records, P.O. Box 68760, Division of Vital funeral Certification: After or Attending

efter death. Director: Aft 24 hours e Hospital

completely filled in by Medical To the To the To the

29b. Signature end title of certifier Q mi

investigation

6 ☐ Could not be determined

2 Accident

4 D Homicide

(Check only one)

MAR 0 2 1999

3 ☐ Suicide

29a. Certifier

2 Medical Examinar: On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number D-25640

1🗹 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as steted.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

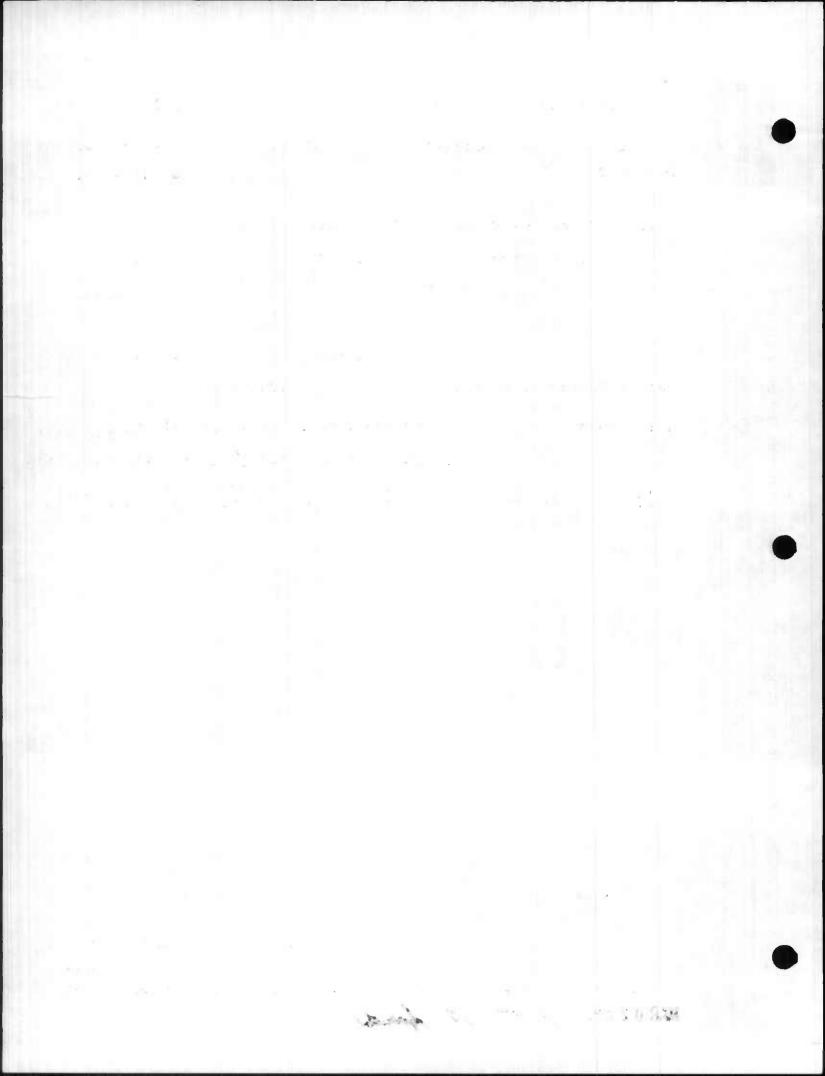
February 27, 1999

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

Khosrow Dauachi, M.D. 1328 Southern Ave, #202, Washington, DC 31. Date filed (Month, Dey, Yeer) 32. Registrar's Signature

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 08707

Dharini		1. Decedent's Nama (First, Middla, La				rtificate c	WITTE	2. Data of De		Voca	3. Time of Death						
Physician /Medical		LUCILLE	S. BED	FORD				FEB. 2	28, Day 199	9 Š ^{ear}	12:00 NO						
Examiner		ta. Facility Nama (If not institution, giv NATIONAL LUT)					4b. City, Town	, or Location of Death ${ m LLE}$			RY CO.						
Funeral Director		5. Social Sacurity Number 6. S 055-10-6778	ax 7. □ M 2X F	Aga (In yrs.	last birthday) Yrs.	If Under 1 Ya Months Da		Hrs. 8. Data of Bird Min. (Month, Da OCT • 25	, Yaer) , 1901	9. Birthpl Count VII	laca (State or Foreign try) RGINIA						
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riter must be notified from must be notified Funeral Director	-	10e. Street end Number 9701- VEIRS	DRIVE			10f. Zip Cod	20850		10g. Citizan of U	What Coun	try?						
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marked other matic evant, I	17. Father's Nam CH	17. Fathar's Nama (First, Middla, Last) CHARLES A.		N				Nama (First, Middla, BERTA AI		na)	*						
27 is mai		19a. Informant's Name/Ralationship (REV.DR. REICHA		UTOR		-		r Rural Route Number			,						
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al Director: After ted in by the funers Certification:		3 ☐ Suicida 6 ☐ Could not be detarmined	28a. Place of	Injury - At he atc. (Specif	oma, farm, stra y)	aat, factory, offic	00	28f. Location (5 City or Ton	Straat and Numb m, Stata)	er or Rural	l Routa Number,						
To the Funeral Direction of the Completely filled in the Medical Certi		one) 2 Medicat Exam	rsicien: To the be iner: On the basis and mannar	of examina	wladga, deeth tion and/or Inv	estigetion, in m	y opinion, death o	lece, end dua to tha occurred et the time,	causa(s) and ma dete and place,	annar as ste and dua to	eted. the cause(s)						
M M	2	29b. Signature end title of couling	enn	m	0	29c. Lice	3661	8	Februa	111	- 16						
)	3	0. Name and address of parson who o					ETRS DE	R., ROCKY	/II/E.	MD.							
State	3	11. Data filad (Month, Day, Year)	32. Regi	strar's Signa	itura												

DHMH 16 Rsv 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 3:32 P4 Mary ELLON BAKER 03 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** MEDICAL SYSTEM UNIVERSITY OF MARYCAND Baltimore Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 20 F Director Jan.6,1925 219-20-4289 PA. Usual Residence of Deceden 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumetic ayant, the Medical Examiner must be notified at MD 1 Yes 2 No Washington Director Clear Spring, 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 12534 St. Paul Road 21722 U.S.A. 234 death Funeral Reme Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 "natural", or white 1□Yes 2X No Specify: White by 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) if Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) residence 8th grade Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic avant ans. Be Nathan A. Hornbaker Elsie Prudence Drury 0 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy J. Baker 12534 St. Paul Rd. Clear Spring, MD 21722 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Shanktown Cemetery Mar 8,1999 Big Pool, MD 4 ☐ Donation _5 ☐ Other (Specify) 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc. P.O.BOX 310 Clear Spring, MD 21722 23a. Part Emer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. First only one cause on each line. Approximate Interval Between Onset and Death Physician HEART FAILURE /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Que to (or as a consequence of): Physician/Medical Examiner STENOSIS certificate be executed physician and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Due to (or as a consequenca of): attending p P.O. Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the 1 Yee 2 No 2 3 Probably 4 Unknown signed b Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peeu 2 1 No 1 ☐ Yes 2 No certificata Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

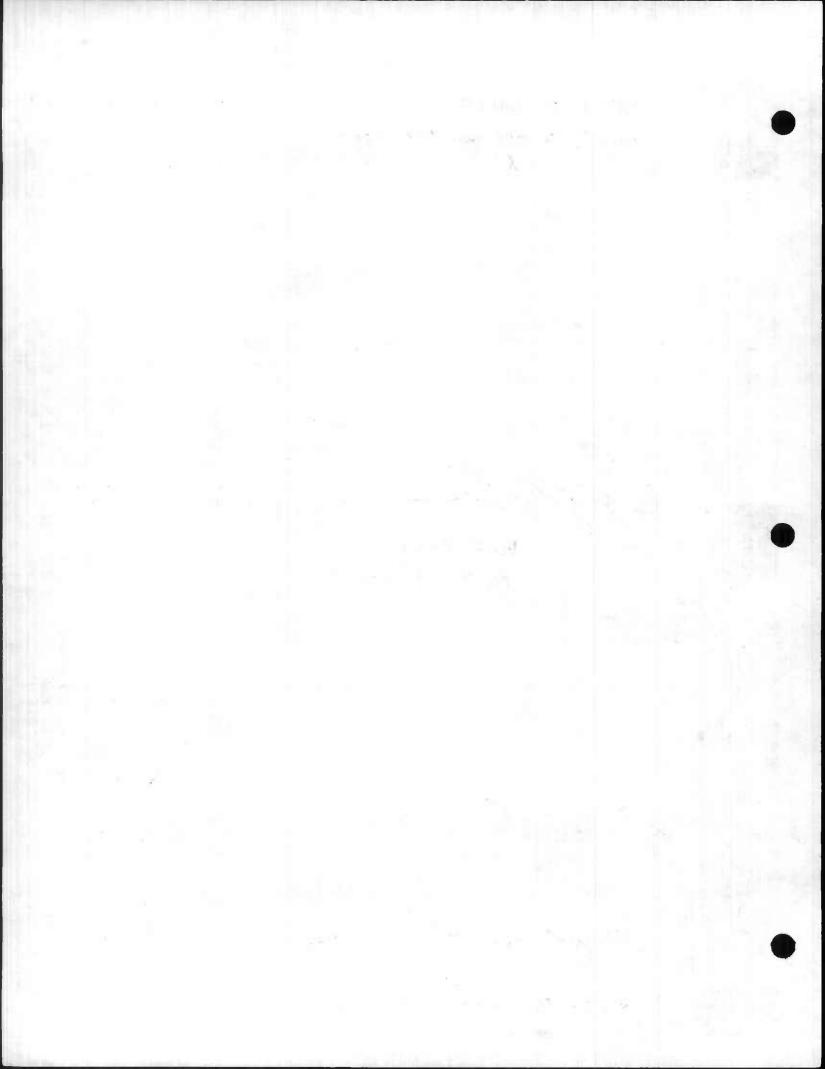
To the Funeral Director: After this certifical completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted. edical 29a. Certifier (Check only one) 29b. Signature and title of certifles 29c. License number 29d. Date signed (Month, Day, Year) RESIDENT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22S.Greene St.P.O.Box 103 Baltimore, MD 21201 Kurt Wehberg 31. Date filed (Month, Day, Year) MAR 0 8 1999

State Registrar

DHMH 16 Rev 6/95

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Margaret Amelia Bierley lanch 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington County Hospital Magerstown Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foraign Country) 8. Date of Birth (Month, Day, Year) Days 1 M 2 F 214-09-3646 Yrs 1904 Maryland Sept. 11. Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 Yes 2 □ No Washington Funkstown: 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 220 E. Chestnut Street 21734 Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 21 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Stanley Manufacturing Elementery/Secondary (0-12) 12 College (1-4or 5+) Fabric Puller Chambersburg, Pa. 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surname) Edward William Bierley Luella A. Moats 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Hagerstown, Maryland 21740 Date 20c. Location - City or Town. State Shirley E. Hessong 9647 Sharpsburg Pike Friend 20b. Place of Disposition (Name of cemetary, cramatory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State Funkstown Cemetery 3/13/99 4 ☐ Donation 5 ☐ Othar (Specify) Funkstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich 305 N. Potomac Street Funeral Home Hagerstown, Maryland 21740 antar the mode of dying, such as cardiac or respiratory arrest, Approximate 23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or haart failure. List only one causa on aach lina. Interval Between Onset end Deeth Immediate Cause (Final lumma diseese or condition resulting in death) Due to (or es e consequence of) week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants Due to (or es a consequence of)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

or items 23s or 28s-f show miner must be notified at

natural, or

la marked

: If item 27 I

Peges 1 and 2 should be filed within 72 hours after death nent of Health end Mental Hygiene.

Baitimore, Maryland 21215-0020

Director

Funeral

Be Completed

Physician/Medical Examiner

or Attending Physician: The lew requires that the death certificate be executed

this

within 24 hours after death.

To the Funeral Director: Al the Hospital

Division of Vital Records, P.O.

Be Completed by Medical Certification: To

29a. Certifian

29b. Signeture end title of certifier

31. Dete filed (Month, Day, Year)

MAR 1 5 1999

30-Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

2031

32. Registrer's Signature

resulting in death) Last	· Complete	Heart 1	Stock Stoli	s lost laune	Ker -
Part II. Other significant conditions of	ontributing to death but not res	sulting in the underfyin	g cause given in Part I.	23b. Did tobacco use co	ontribute to the cause of death? 3□ Probably 4☑Unknow
				24a. Was en eutopsy performed?	24b. Wera autopsy findings evailable prior to completion of cause of death?
25. Was case referred to medical examiner?	Macrital			eath (Check only one)	
1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpetient 3□	DOA Other: 4 Nursing I	Home 5 ☐ Residence 6 ☐ Oth	nar (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of fnjury	28c. Injury at Work? 1 Yes 2 No	28d. Dascribe how injury occur	Derr
3 Suicide 6 Could not be determined	28a. Place of Injury - At h building, etc. (Specia	oma, farm, street, fact fy)	ory, office	28f. Location (Street end Numb City or Town, Stata)	ber or Rurel Route Number,

1 Certifying Physician: To the best of my knowledga, death occurred at the time, date and place, and dua to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

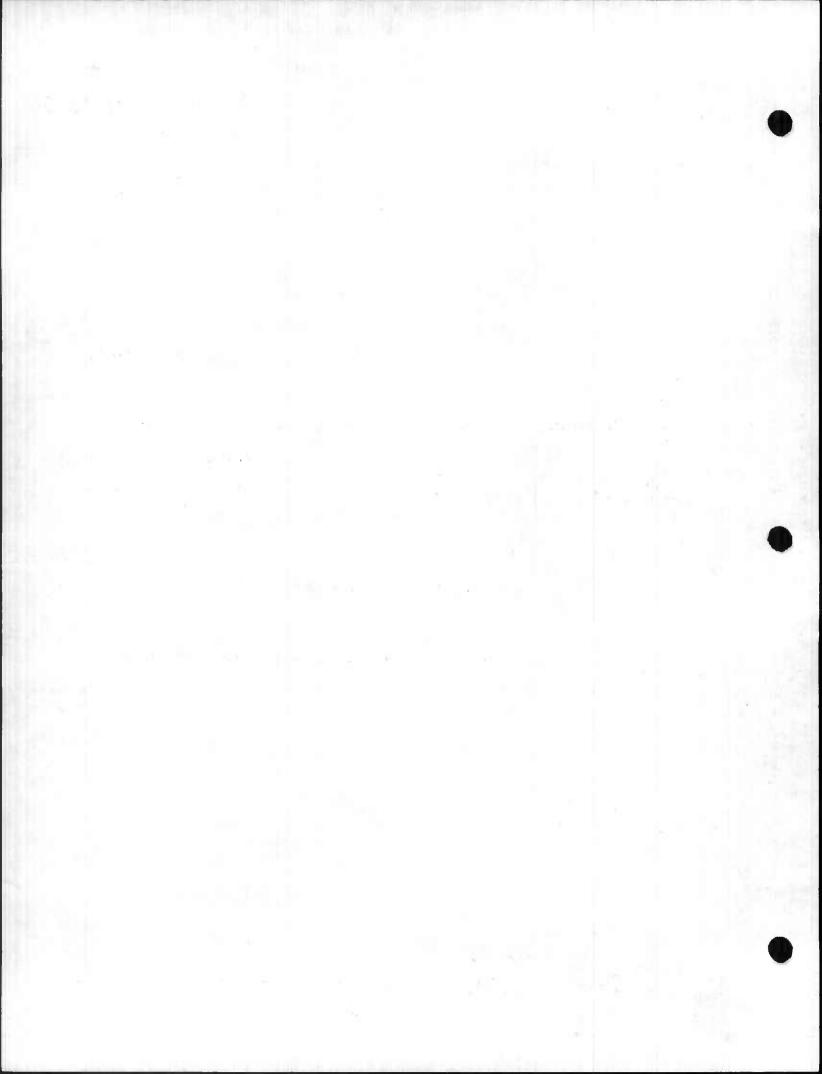
29d. Date signed (Month, Day, Year)

Goonsboro

State Registrar

DHMH 16 Rev 6/95

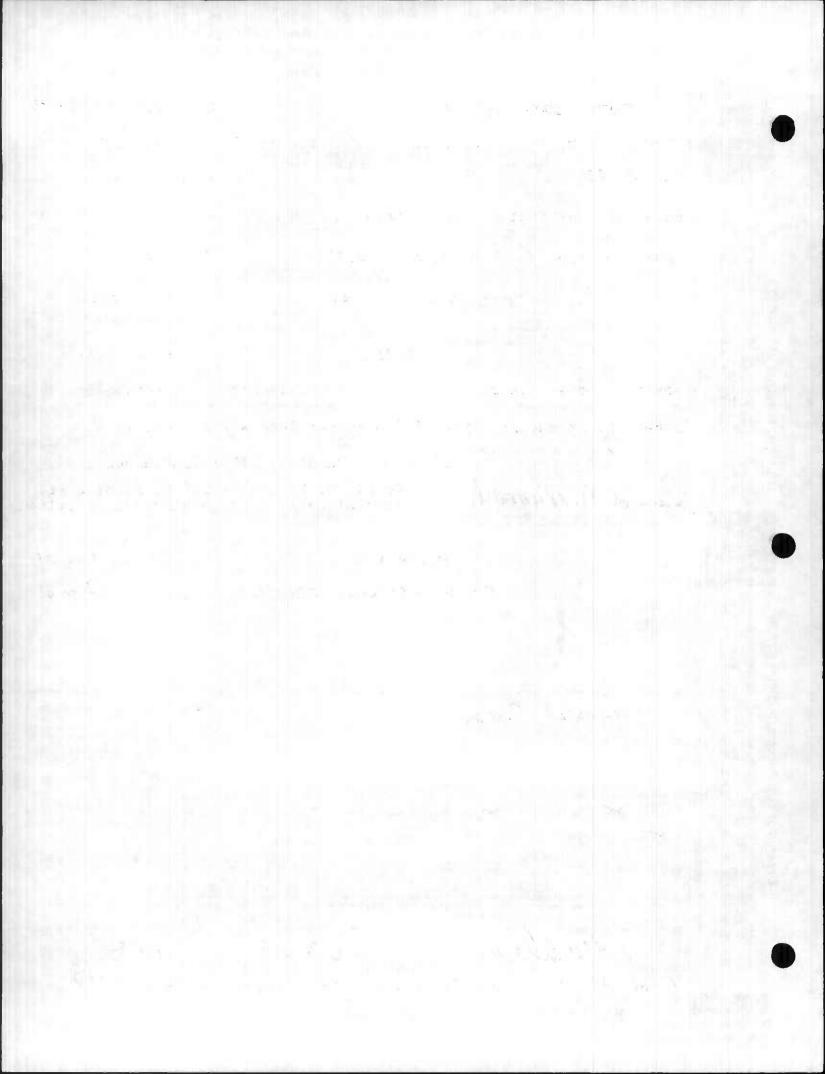
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 087

				Certifica	te of I	Death		Reg. No.	U0	/ U	
1. 1.	1. Decedent's Name (First, Middle, La	st)	= = 51			- 10	2. Date of De	eth Day	Year 3.	Time of Deeth	
Physician /Medical	ROBERT LE	WIS BEERS	SR.				MARCH		2	20 PM	
Examiner	4a Facility Name (If not institution, giv	e street and number)			4	b. City, Town, or	Location of Deeth	4c. County	of Death		
	Frederick Mem					Freder	ick	Frede	rick		
Funeral	5. Social Security Number 6. S	Sex 7. Ag	e (In yrs. lest birtl	Months	Deys	If Under 24 Hrs Hours Min		h y, Year)	9. Birthplece (Country)	Stete or Foreig	
Director	025 03 1635	9	00 4	rs.			October 1		Ohio		
bue *	Usuel Residence of Decedent 10a. State 10b. County	10d. in	side City Limit								
Aarylen f ehow		ington	Hagers	town					11	□Yes 2√□N	
the Man 288-f et notified rector	10e. Street and Number				ip Code			10g. Citizen of V	What Country?		
With With		TT = d = la a =	D						rnot country t		
iter death with the Maryland r items 23s or 28s-f show net must be notified at Funeral Director	13815 Woodland	12. Was Decedent		_	1742		Specify Yes or No	USA 14. Bac	e - American Inc	dian.	
	1 Never Married 2 Married	Armed Forces?	No.	If Yes, sp	ecify Cuba	ın, Mexican, Puè	to Rican, etc.)	Blac	ck, White, etc.	Die 1	
. 0	3 ☐ Widowed 4 ☐ Divorced	fy Yes 2 ☐ N If Yes, Give Year or Dates:	WW 2	1 ☐ Yes	2 No	Specify:		Specify	White		
"natural", or its	15. Decedent's Ed		16a. I	Decedent's Us	ual Occup	ation		16b. Kind of Bu	usiness/Industry	,	
c * 9 -	(Specify only highest green Elementary/Secondary (0-12)	College (1-4or 5		(Give kind of w life. DO NOT	ork done o use retired	during most of wo	orking				
d with	Lientendry Cocondary (C 12)	4		ffice	r			Corre	ctions	3	
be filed d other event, I	17. Father's Neme (First, Middle, Last,					18. Mother's Ne	me (First, Middle,	Maiden Sumen	ie)		
ges 1 and 2 should be filed within to Health and Mental Hygiena. If item 27 is marked other than or other traumatic event, the Mercother traumatic event.	Wayland Lewis	Beers	1.00			Eliza	beth	Bea	rdsley	7	
2 sho and I is me	19a. Informant's Name/Relationship (Type, Print)	19b.	Meiling Addres	s (Street	end Number or F	lurel Route Number	er, City or Town,	State, Zip Code	9)	
Health Health Iom 27 i	Robert L. Beer	s. Jr.	Son 11	404 R	enne	r Road	Keymar	. Md.	21757		
of He	20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐		20b. Place of cemetery	Disposition (No.	eme of other plea	e)	Date	20c. Location -	City or Town, S	Stete	
Pag nent int: M	4 □ Donation 5 □ Other (Specif		Smiths	burg	Crem	atorv	3/10/99	Smiths	burg.	Md.	
permit. Pages 1 e Department of Hei Important: If flem any Injury or othe ance.	21. Signature of Funeral Service Licer	isee ,		22. Name a	nd Addre	ss of Fecility					
e e E e e	22. Name and Address of Fecility Gerald N. Minnich 305 N. Pot Funeral Home Hagerstown 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,										
	23a. Part1. Enter the disease, or com	plications that caused	I the death. Do no	ot enter the mo	a I H	g, such as cardia	nc or respiratory a	gersto rrest,	wn, Ma	rylar	
Physician	snock, or near failure. List only	one cause on each in	16.						Ons	vel Between et and Death	
/Medical	Immediate Cause (Final		1000						1	unk	
Examiner	disease or condition resulting in death) Die to (or as a consequence of):										
i i		o. Cerebro vairolor accedent								nek	
icate be axecuted physicien end s the buriel-transit											
se axe sign of a	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury										
death certificate be axecu e attending physicien end of for use as the buriet-tra iclan/Medical Exar	thet initieted events resulting in death) Last	0.	Due to (or es a co	onsequence of):						
M ea		d									
ath corus		•									
The law requires that the death cer- cate hes been signed by the attendin paga 2 should be detached for use Completed by Physiclan/N	Part II. Other aignificent conditions of	ontributing to death be	ut not resulting in	the underlying	cause giv	en in Part I.	23b. Did	tobacco uae co	ntribute to the	cause of dear	
that the ed by detac	laryngeal	Concen					78	Yes 2□ No	3 Probably	4 Unkn	
ras ti							· ·	100001000	24b. Were eu	utonov finding	
requiras been sign hould be							perfo	an autopsy ormed?	availeble	e prior to tion of cause	
hes b a 2 s mpi									of death	1?	
. page							10	Yes 2 2 No	1 ☐ Yes	2 □ No	
Physician: Tha law this certificate hes ral director, paga 2 : To Be Comp	25. Was case referred to medical examiner?	Hospitel:			Oth		eth (Check only	one)			
this cal dir.	1 Yes 22No	Inpatie			_	4 Li Ivuising	Home 5 ☐ Resi				
ing F.	27. Menner of Deeth Solution Natural 5 □ Pending	28e. Dete of Inju (Month, Day	ry Year) 28b. Ti	jury	28c. Injur Wor		280. Describe	how injury occur	red		
tal or Attending P rs after death. al Director: After ti led in by the funera Certification:	2 Accident investigation 3 Suicide 6 Could not b			М		Yes 2 □ No					
or At after of Direct in by	4 ☐ Homicide determined	28e. Place of Inju- building, etc	ury - At home, far c. <i>(Specify)</i>	m, street, facto	ry, office		City or To	Street end Numb wn, Stete)	er or Hurei Hou	ite Number,	
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi complataly filled in by the funeral Medical Certification: 7							la The				
To the Hospital within 24 hours to the Funeral complately filled	(Check only 2 Medical Exar	yaician: To the best on niner: On the basis of	examination and								
thin 2 of the of	one)	and manner sta	ated.	2	Do Licono	o aumbas		20d Data signa	d (Month Day	Veesl	
T Will	29b. Signeture and title of certifier	1/1		2	9c. Licens	יויייייייייייייייייייייייייייייייייייי		29d. Date signe	(Month, Day,	(dai)	
	/ remy	W M)			0	5/05 P		3/10	199		
	30. Name and address of person who	completed cause of d	eeth (Item 23e) (1	Type, Print)	, ,		1.1	1	2.20)	
March Co.	Wine Ah MI	10200	Copper	mint	KY	000	1dv horo	My	41147	/	
State	31. Dete filed (Month, Day, Yeer)	750	er's Signature	6. 1.	no v	11					



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State of Maryland / Department of Health and Mental Hygiene O O Certificate of Death 2. Data of Death 1. Decedent's Name (First, Middla, Last) 3. Time of Death **Physician** 11:52 PM 9 Ima Eileen Bowers March /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Washington County Hospital Washington Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1□M 2×F Months Yrs. 217-58-3350 69 May 19, 1929 West Virginia Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic svent, the Medical Exandrian must be notified as 1 ☐ Yes 2 No Director Williamsport Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Counfry? 8819 Downsville Pike 21795 USA Funeral 12. Was Decedanf Ever in U,S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Navar Married XX Married "natural", or 1 ☐ Yas 2X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT usa retired) d 2 should be filed within 72 th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Coordinator Education 18. Mother's Name (First, Middle, Maidan Surname) 17. Father's Name (First, Middla, Last) permit. Peges 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked or any Injury or other traumatic ave Esrom Romanus Hiett Elizabeth Ambrose 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. informant's Name/Ralationship (Typa, Print) 8819 Downsville Pike Williamsport, Maryland 21795 James A. Bowers/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal/from Stata 4 Donation 5 Dothar (Specify) Greenlawn Memorial Park 3-13-99 Williamsport, Maryland 22. Name and Address of Facility
Osborne Funeral Home 21. Signature of Fureral Service License 425 S. Conococheague St.Williamsport, MD 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical immediate Cause (Final disaasa or condition resulting in death) Hocurs Examiner Examiner DIOCATI The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaasa or injury that initiated events resulting in death) Last pue physician er s the buriel-t CHTOPWIA Box 68760 Physician/Medicai a to (or as 23b. Did tobacco use contribute to the cause of death? ed by the detached Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed peen completion of cause of death? has page 2 is certificate h NTHAUARCUCAN 2 PINO 1 ☐ Yas 2 ☐ No Division of Vital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Yes 2 ₹No 1 Impatiant 2 ER/Outpatient 3 DOA After thi funeral 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Mannar of-Death 28b. Time of 28c. Injury at Work? Certification: 1 BNatural 5 Pending 1 Yas 2 No death. investigation 2 Accident efter deatl Director: 6 Could not be datarminad 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, straat, factory, offica building, atc. (Spacify) 4 Homicide 24 hours eft Funeral Di letely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the causa(s) and manner as stated 2 Medical Examiner; On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the 29a. Certifier Medical on the basis of axamination and/or investigation, in my opinion, daath occurred at the time, date and place, and dua to tha causa(s) Within 2. To the F ind manner stated. 29b. Signature 29c. License number 29d. Date signed (Menth, Day, Year) ALLIC nd addrass of perso impleted causa of daath (I TEATER

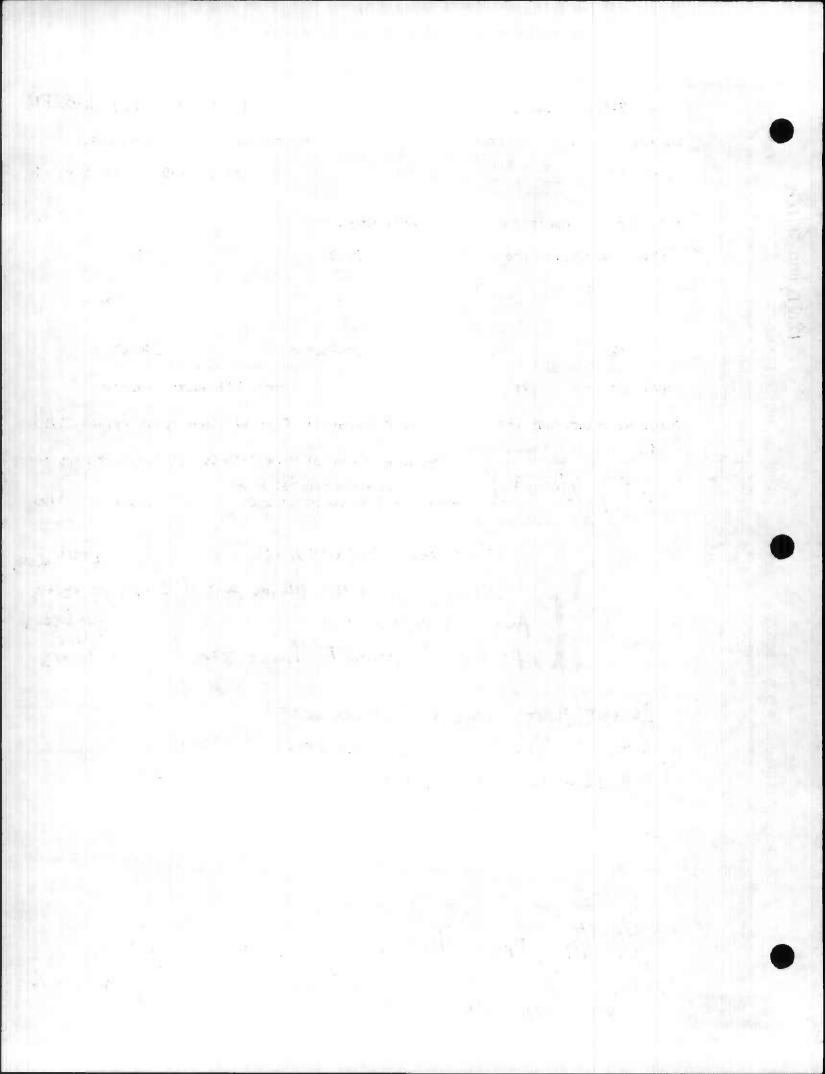
32. Registrar's Signature

Registra

31. Data filed (Month, Day, Year)

MAR 1

BWES, Ima Gileer



P.O. Records, Vital of

BUIS

ELIZABETH

Box 68760 98 od ber sign Dec page 2 certificata or Attending Physician: director, this funeral After Division 24 hours after death.

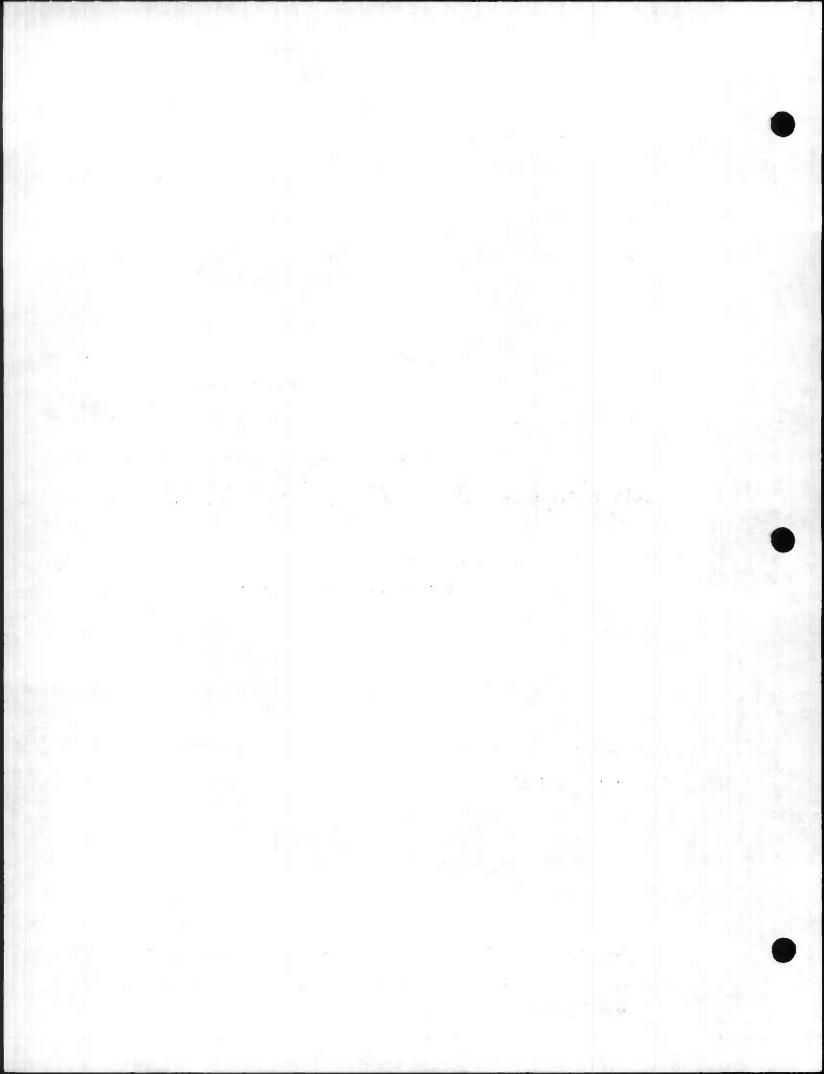
Funeral Director: A completely filled in by Hospital within 2 ş 2

1. Decedent's Name (First, Middle, Last) 2. Data of Death Month Day Year **Physician** Mary Elizabeth Buis 1999 9:07 AM MARCH /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner RAVENWOOD LUTHERAN VILLAGE WASHINGTON HAGERSTOWN If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) **Funeral** Hours 1□M 2⊠F 85 Yrs. 219-12-9182 May 6, **Director** Towa Usuel Residence of Decedent death with the Meryland 10b. County 10c. City, Town or Location 10d. Inside City Limits "netural", or items 23s or 28s-f show rolcal Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Washington County Hagerstown 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 6010 Clevelandtown Road 21713 Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. Peges 1 and 2 should be filed within 72 hours after ment of Health and Mentel Hygiene.
ant: If item 27 is marked other than "natural; or ite ury or other thaumatic avent, the Medical Essention ury or other traumatic avent, the Medical Essention. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Merried 2 Married Specify: White 21215-0020 1 ☐ Yes 2 No Specify: p 3 NWidowed 4 □ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Grocery Store 12 Manager Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earle H. Harding Effie J. LaVern 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonita Pickett/Daughter 6010 Clevelandtown Road, Boonsboro, Maryland 21713 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Department important: If any injury or 4 ☐ Donetion 5 ☐ Other (Specify) Mar.8 Boonsboro, Maryland Boonsboro Cemetery 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funerel Sen 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediete Ceuse (Finel diseese or condition resulting In death) Acute Bronchopneumonia 1 Week Examiner Due to (or es a consequence of): Examine Chronic obstructive pulmonary disease many years the burial-trensit Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting In death) Last Due to (or as a consequence of) Physician/Medical Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably CUnknown Chronic bronchoectasis þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an autoosy Gastroesophageal reflux disease 1 ☐ Yes 2 🖾 No 1 ☐ Yes 2 ☐ No Polymyalgia rheumatica 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: Other: 45 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes 2♥ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Deleturel
2 Accident 5 Pending 1 Yes 2 No investigetion 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) D07857 MARCH 5, 1999 1/ Leen 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Edson Moody, MD 1190 MT. Aetna Road Hagerstown, MD 21740 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 8 1999 Registrar DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** March 4c. County of Death /Medical City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner ulano George 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2 F Months Days Hours Yrs **Director** Usual Residence of Decedent with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 2 No 1 Yes Directo MINE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3200 rn 2001 Funeral deeth 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decadent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours efter Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or ite any Injury or other treumatic event, the Medical Examina. 1□ Yes No Never Married 2 ☐ Married altimore, Maryland 21215-0020 Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) Be lower 0 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Brandywine, MD Molly Berry 13209 CIT MOT 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Logation - City of Town, State 1 Durial 2 Cremation 3 Removal from State 03-06-1999 St. Paul's Cemetery Baden, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
The Huntt Funeral Home, Inc. JOHN P. 20604 P.O. Box 156, Waldorf, Maryland KNISLEY M01164 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical **Examiner** Examiner requires that the death certificate be executed g physician end as the burial-tran Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequenca of): 980 for signed by the a P.O. 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to page 2 should Completed peen completion of ceuse of death? certificate hes 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Impatient 2 ER/Outpetient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury at Work? Certification: 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No 24 hours efter death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) end manner stated. (Check only one) To the To the To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0015 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURRATTS ROAD

32. Registrar's Signature

7501

1999

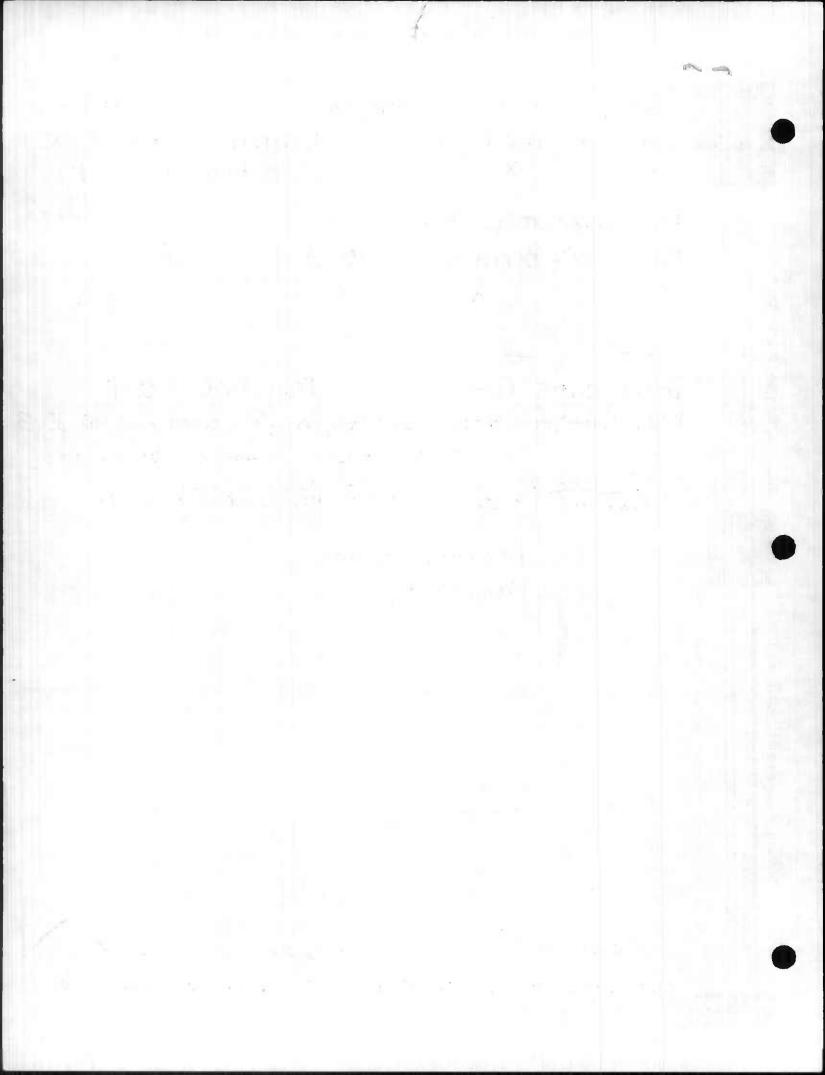
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#207 CLINTON, MARYLAND 20735-3388

State Registrar ARTHUR E.

31. Date filed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

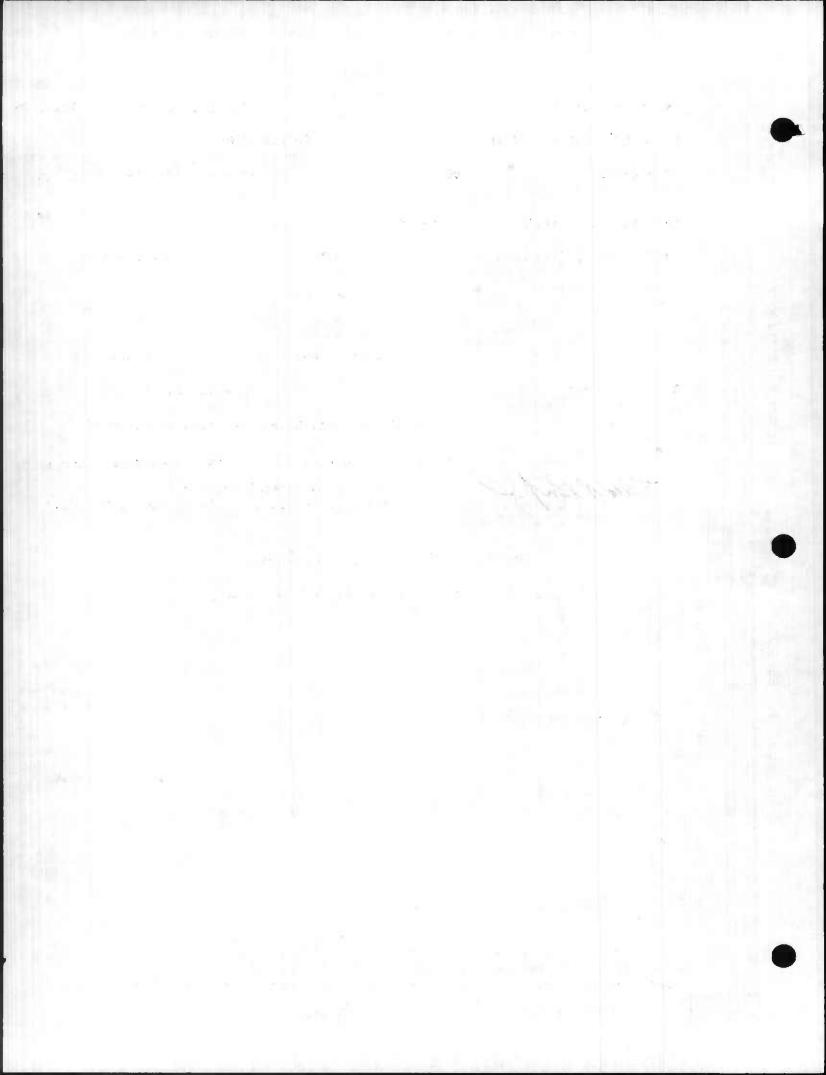
State of Maryland / Department of Health and Mental Hygiene 9 087 1

			Certificate of L	Death	Reg. No.	00/14		
Physician	1. Decedent's Name (First, Middle, Last) James Taylor	Clenny, II		2. Dete of Month	f Death Day	3. Time of Death 999 2:40 pm		
/Medical Examiner	4a Facility Nama (If not Institution, give stree Futurecare – Che		4	b. City, Town, or Location of C Arnold	Deeth 4c. County of			
Funeral Director	5. Social Security Number 6. Sex 12 M	7. Age (In yrs. last bit 8 4	rthday) If Undar 1 Yeer Yrs. Months Deys	Hours Min. 8. Data of (Mont)	Birth Yeer) 1914	9. Birthplece (State or Foreign Country) Kansas		
the Maryland 28s-f show notified at	Usuet Residence of Decedent	del 10c. City, Tow			10d. Insida City Limil 1 ☐ Yas 2 💇 N			
flar death with the Mar ritems 23s or 28s-f si ther must be notified Funeral Director	10e. Street and Number 305 College Park	way	10f. Zip Code 21 0 1	2		. Citizen of Whet Country? USA		
8 0	1 Navar Married 2 Married	Wes Decedent Ever in U,S. Armed Forcas? I □ Yas 2 ② No If Yes, Give Yeer or Detes:	13. Was Decedent of HI If Yas, specify Cube 1 □ Yes 2☒ No	spanic Origin? (Specify Yes on n, Mexican, Puerto Rican, etc Specify:	or No- 14. Race Bleck, Specify:	American Indian, White, etc. White		
c • 6 -	15. Decedent's Education (Specify only highest grade contentery/Secondary (0-12)	Me Me	Decedant's Usuel Occup (Give kind of work done of life. DO NOT use retired talurgical	otlon furing most of working Engineer	16b. Kind of Busi			
Hiled Other	17. Fether's Neme (First, Middle, Last)	5+		18. Mother's Name (First, Mi	iddle, Maiden Sumeme,			
should be filed within and Mental Hygiana. To Be Comp	James Taylor	Clenny, I		Nellie :	Peet			
0 6 6 6	19e. informent's Name/Reletionship (Type, Leslie Madison /			Pkwy., Sev				
omit. Peges 1 and Deptiment of Health mortant: if Item 27 my injury or other to	20a. Method of Disposition 1 □ Burial 2 ☑ Cramation 3 □ Ram 4 □ Donetion 5 □ Other (Specify)	yarrom Stete/	of Disposition (Name of any, cremetory or other please aneake Cre	Mar 2	20c. Location - C	ity or Town, Steta		
Physician /Medical Examiner Examiner Examiner	Immediate Cause (Final days or condition as	Pheum	consequence of):			2 Days		
ng physicia es tha bur Medical	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest		consequence of):					
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The law requires that the set has been signed by the page 2 should be detechn.	Cornery Portery	Durane		24a.	Was an autopsy performed?	24b. Were eutopsy findings evallabla prior to completion of cause of deeth?		
8 C 8 E					1 Yas 2 No	1 ☐ Yes 2 ☐ No		
certificate rector, pag	25. Wes case referred to medical			26. Place of Deeth (Check of	only one)			
Z 85 Z	examinar? 1 ☐ Yes 2 No Hosp	itel: 1 Inpatient 2 ER/O	utpatient 3 DOA Oth	4 Nursing Home 5				
v Attending fler death. irector: After in by the fune rtification	2 Accident Investigation			(? Yes 2 □ No	28d. Describe how Injury occurred 28f. Location (Street end Number or Rural Route Number, City or Town, Stere)			
To the Hospital o within 24 hours at To the Funeral Di complately filled ii		n: To the best of my knowledge On the basis of examination er end manner stated.						
To the compla	29b. Signature and titla of certifiar Whynice 19	Attending:	29c. Licanso	11684	3-2-	(Month, Day, Year)		
	30. Name and address of person who compile C-V-C-4RIAC. M-L	eted cause of deeth (Item 23a)	(Type, Print)	4, PASTOR	ENA MO	21122		

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				C	ertifica	te of	Death		F	leg. No.		
	1. Decedant's Nama (First, Mi	ddia, Last)				110			2. Data of Dea Month	th Day	Year	3. Tima of Death
Physician /Medical	Jessie May Cr	yer							March 6		1001	12:45 PM
Examiner	4a Facility Nama (If not institu						4b. City, To	own, or Lo	cation of Death	4c. County	of Death	
	St. Mary's Nu	rsing Cer	nter					nardt			. Ma	ry's
eral	5. Social Security Number	6. Sax		(In yrs. last birthda		or 1 Year Days	If Undar Hours	24 Hrs. Min.	8. Data of Birth (Month, Day	Year)	9. Birthp	laca (Stata or Foreign
tor	578-66-7755	1□ M 2	94 Yrs.			,-		D	ecember	19,190)4]	Maryland
ral Director	Usual Rasidance of Decedent 10a. Stata 10b. Cou	nh.	1.	10c. City, Town or	Location						1	0d. Insida City Limits
-												1 ☐ Yes 2 No
Sc		Mary's		Leonard	nardtown							
Director	10e. Street and Number		10f. Zip Code							log. Citizan of \	What Cour	ntry?
<u>e</u>	42482 Medleys		Road 206							United		
by Funeral	11. Maritai Status	Arme	Was Decedant Ever in U.S. 13. Was Dacedent If Yas, specify C				Hispanic Or oan, Maxicai	igin? (Spa n, Puarto l	cify Yas or No- Rican, etc.)		a - Americ ck, Whita,	
E >	1 Never Married 2 N	. If Ya	Yas 2 PNo is, Give		1□ Yes	2 No	Specify:			Specify		
q p	3 ₩ Widowed 4 Divorce		r or Datas:									hite
lury or other traumatic ever		lent's Education hast grade comple	eted)	(G	cedant's Us va kind of w	ork dona	during mos	st of working	ng	16b. Kind of B	usinass/In	dustry
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	12	ila (Ast)		Registered		ed Nu		arta Niama	(First, Middla,		dical	
	17. Father's Nama (First, Midd										ia)	
	Richard Latha								izabeth			
	19a. Informant's Name/Ralati	onship (Type, Print	t)	19b. M	iling Addras	s (Stree	t and Numb	er or Rura	I Routa Numbe	r, City or Town,	Stata, Zip	Coda)
	Ann Loker				41300 Solitude Lane,							
	20a. Mathod of Disposition 1 Burial 2 Cramatic	n 3 DRamoval	from Stata	20b. Placa of Discamatary, of	position (Na rematory or	ama of othar pla	ice)	1	Data	20c. Location	City or To	own, Steta
	4 □ Donetion 5 □ Other		7	Our Lad	y's Ce	emete	ery	3/	10/99	Leonard	town	Maryland
	21. Signature of Eunaral Serv	CO JACOB SOUL					ass of Facili	ity				
8	Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, N											
	23a, Part1. Entar tha disaasa	or complications	that causad th	ha daath. Do not	antar the mo	da of dy	ing, such as	cardiac o	r respiratory an	nardcow rast,	/II , MI	Approximata
an l	shock, or haart failura.	lst only ona causa	a on aach line).							1	Interval Between Onset and Death
	Immediata Cause (Final	A.	015/)	1					
r	Immediate Cause (Final disease or condition resulting in death) a Multiple System Jacket Dua to (or as a consequence of): b. Hullung of September 1. Dua to (or as a donsequence of):											
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rie .	Entract Control	b	ull	wen	2- 1	Sy	udr	one	-			
xa	Sequentially list conditions, if any, laading to immediate causa. Entar Undarlying Causa (Diseasa or Injury		(D	ua to (or as auton	saquance of): /						
700	Causa (Diseasa or Injury that initiated avants	c										
edical Examiner	rasulting in death) Last		Di	ua to (or as a con	equence of):						
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by Physician												
ysi	Part II. Other significant cond			not rasulting In th	underlying	causa g	ivan in Part	1.		0.0		o the cause of death?
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Be	25. Was casa refarred to med	ical					26. Ptec	e of Death	(Check only o	na)	A	
To	examinar? 1 Yas 2 No	Hospital:	1 Inpatiant	t 2 ER/Outpa	tient 3 🗆 C	OA OI	ther: 450N	ursing Ho	ma 5□Rasio	lanca 6 Oti	nar (Speci	(y)
	27. Manner of Deeth		Dete of tnjury	28b. Tim	of	28c. Inju	- 1	-	28d. Describe h			
tio	1 Vatural 5 Per	ding estigation	(Month, Day	Year) Inju	M		Yas 2] No				
Certification:	3 ☐ Suicide 6 ☐ Cou	ld not be 28a.	Placa of Injur	y - At home, ferm,	street, facto	ry, offica	l				ber or Run	al Routa Number,
- t	4 Homicida		building, etc.	(Specify)					City or Tow	mi, Stata)		
0	29a. Cartifiar 11 Certi	ying Physicien: T	o the best of	my knowledge, de	ath occurre	d at tha t	ime. dete er	nd pleca.	end dua to tha	cause(s) end m	enner as s	steted.
edicai		al Examinar: On		xamination and/o								
Medicai Certification:	29h. Signature and title of cen	1100	Trial in tall		2	9c. Lican	isa nu <i>m</i> bar			29d. Date signe	ed (Month,	Day, Year)
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	30. Nama and address of pers											
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State			32. Registrar		4	lan	P.					
State Registrar	John Fénwick, 31. Data filad (Month, Day, Ye MAR		32. Registrar	50 Cedar	Lane 6.	par		eonar	dtown,	Marylan	id 20	650



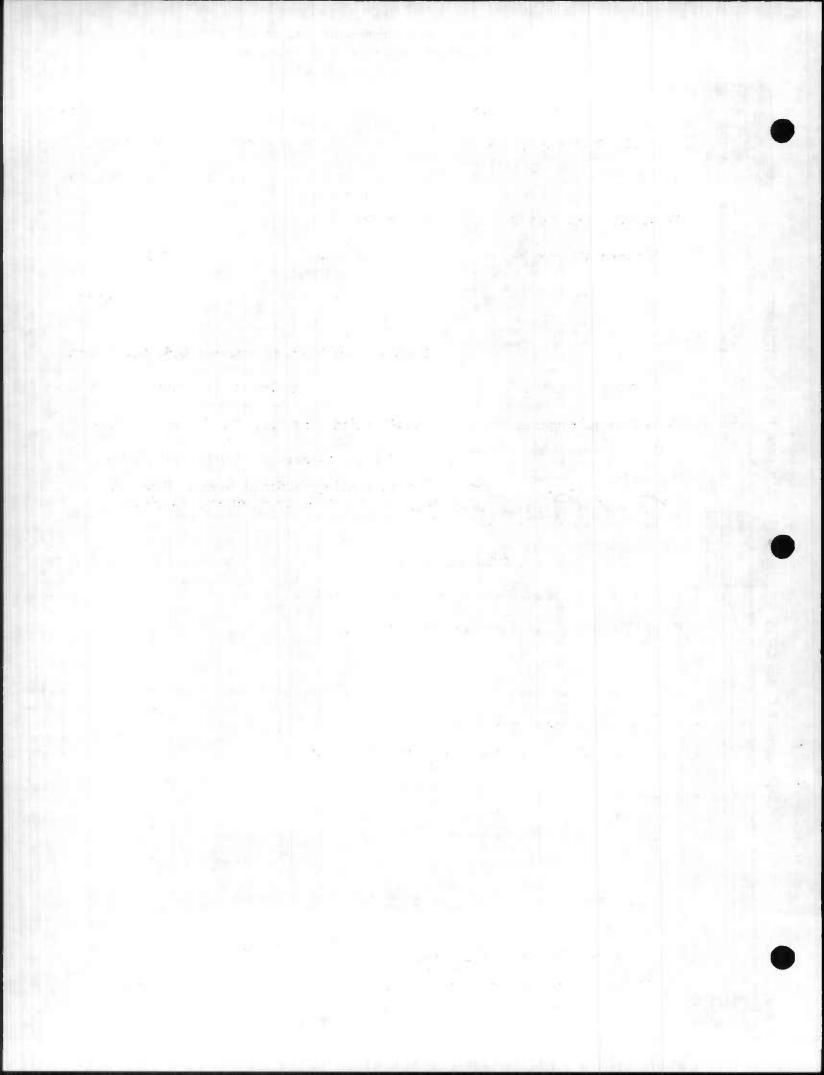
CAMERON

JOHN

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Month **Physician** 1999 March 6 John Woodrow Cameron 12:50p.m. /Medical 4h. City. Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Death Examiner St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) **Funeral** Deys 10XM 2□ F Yrs. Director 212-20-8975 86 February 28,1913 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Insida City Limits 10e. State r 28a-f show 1 ☐ Yes 2 No Maryland St. Mary's Hollywood Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? r than "natural", or items 23s or the Medical Examiner must be 24060 John Cameron Way 20636 U.S.A. death v Funeral 14. Rece - American Indien, Bleck, White, etc. 12. Wes Decedent Ever In U,S. Armed Forcas? Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus filed within 72 hours after Yes 2 No Yes, Give 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 🖾 No White Specify: by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collage (1-4or 5+) Forman Power Plant Operator U.S. Government 7th 7 is marked other traumatic event, i permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked other any injury or other traumatic event, pages. 17. Fether's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maidan Sumeme) Peter Cameron Emily Maria Bean 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Joan Wilson/Daughter 44545 White Pine Ct., California, MD 20619 20b. Plece of Disposition (Neme of cemetery, crematory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oueen of Peace Cemetery 3/10/99 Helen, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A. P.O.Box 270, Leonardtown, MD 20650 called the death of not enter the mode of dying, such as cardiac or respiratory errest, Approximete Intervel Between Onset end Deeth Physician Immediate Ceuse (Final disease or condition rasulting in death) /Medical 24 hr. **Examiner** Examiner physician and s the burial-transit certificate be executed Sequentially list conditions, if eny, leading to immediate causa. Enter Underlying Causa (Disaasa or Injury that Initiated events resulting in death) Lest Box 68760 eun cu Physician/Medical Due to (or es e consequence of) as USB Pert II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contributa to the causa of death? signed by 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, p 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed page 2 should frenue Hydro Cepkelar certificate has 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 □Othar (Specify) 1 ☐ Yas 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA uneral 27. Menner of Deeth 28b. Time of Injury 28d. Dascribe how Injury occurred 28c. Injury et Work? Certification: Division Attending 5 Pending invastigation 1 DONeturel 1 Tyes 2 No r death. 2 Accident Director: 6 Could not be datarminad 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At homa, ferm, street, fectory, office building, etc. (Specify) filled in by 4 D Homicida 8 Hospital 24 hours To Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end mannar es steted.

2 Madical Examinar: On the basis of examinetion end/or investigation, in my opinion, daath occurred et the time, date and place, and due to the cause(s) end menner steted. 29a. Certifian edical completely (Check only within 2 To the 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name end antress of person who completed cause of death (Itom 29a) (Type, Print) John Fenwick Philip J. Bean Medical Ctr. Hollywood, MD 20636 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State MAR 09 1999 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Nema (First, Middla, Last) 2. Date of Death Day Year Clair Edgar Carrick, Sr. February 27, 1999 11:50PM 4b. City, Town, or Location of Daath 4c. County of Death 4e Fecility Neme (If not institution, giva street and number) VA Maryland Health Care System

5. Social Security Number
6. Sex 7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday) Perry Point
If Under 1 Year | If Under 24 Hrs. | 8 De 8. Data of Birth (Month, Day, Year) June 23, 1923 Birthplace (State or Foreign Country) Ohio Months Days Hours Min 290-16-5299 Usual Rasidance of Dacedani 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits XYes 2 □ No Maryland Cecil Perryville 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 611 Franklin Street 21903 U.S.A. 12. Wes Decedant Evar in U,S. Armad Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Race - American Indien. Bleck, Whita, atc. NXYas 2□No If Yas, Giva Yaar or Detes: 1941-46 1 Nevar Married 2 Married 1 ☐ Yas ② No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) 16a. Dacadant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) Bainbridge Naval Training Ctr. Collega (1-4or 5+) Elamantery/Secondary (0-12) Bainbridge, Maryland Four Years Housing Manager 18. Mothar's Nama (First, Middla, Maiden Sumema) 17. Fathar's Nama (First, Middla, Last) Lloyd Edgar Carrick Erma Elizabeth Gobel 19e. Informant's Name/Relationship (Typa, Print) 19b. Malling Address (Street and Number or Rurel Routa Number, City or Town, Stete, Zip Code) Marietta Bines Carrick (wife) 611 Franklin Street, Perryville, Maryland 21903 20b. Place of Disposition (Nama of cematary, crametory or other plece) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata Harford Memorial Gardens 3/4/99 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility 21. Signatura of Funaral Sarvice License 23e. Pert1. Enter the disease, or complications that causad the daeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one causa on each line. Lee A. Patterson & Son Funeral Home 21903-0188 Approximeta intarvai Between Onset and Daeth Immediata Ceuse (Final disaasa or condition rasulting in daath) Lung cancer unknown Dua to (or es a consequance of): Chronic obstructive lung disease unknown Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaase or Injury that initiated avants rasulting in daath) Last Dua to (or es a consequance of): unknown Hypertension Due to (or as e consequence of): Coronary heart disease unknown 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Nunknown 24b. Were autopsy findings eveilable prior to 24a. Was an autopsy completion of cause of death? 1 ☐ Yes 2 No 1□ Yes 2□ No 25. Was casa rafarred to medical axaminar? 26. Pieca of Daath (Check only ona) Hospital: 1 X Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 8 Othar (Specify) 1 Yas 2N No 28e. Date of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Mennar of Deeth 28b. Tima of 28c. Injury at Work? 1 Natural 5 Panding Investigation 1 □ Yas 2 □ No 2 Accident

certificate be executed ettending physician end for use es the bunal-trans Box 68760 thet the death ed by the e o signed by t ۵ Records, requires peen : wa page 2 certificate has The Division of Vital Physician: this funeral After t or Attending As after defilled in 24 hours To the I within 2

Physician

/Medical

Examiner

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Funeral

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Completed

Funeral

Director

r than "natural", or items 23a or the Medical Examiner must be r

al Hygiene.

12 should be fit and Mantal H

permit. Pages 1 and 2 sh Department of Health and Important. If hen 27 is m any injury or other traum ance.

Physician /Medical

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Physician/Medical Examiner

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State Registrar

29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 29c. Licansa number MD D50454 February 28, 1999 omplated causa of deeth (Itam 23a) (Type, Print) 30. Nama and addrass of person ARASTOO YAZDANI, M.D., VA Maryland Health Care System, Perry Point, MD

12 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data end piece, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at tha time, dete end piece, and due to the cause(s) and mannar stated.

28a. Pleca of Injury - At home, farm, streat, factory, offica building, etc. (Specify)

28f. Location (Straat and Number or Rurel Route Number, City or Town, State)

31. Data filed (Month, Day, Yaar) MAR 0 4 1999

3 ☐ Suicide

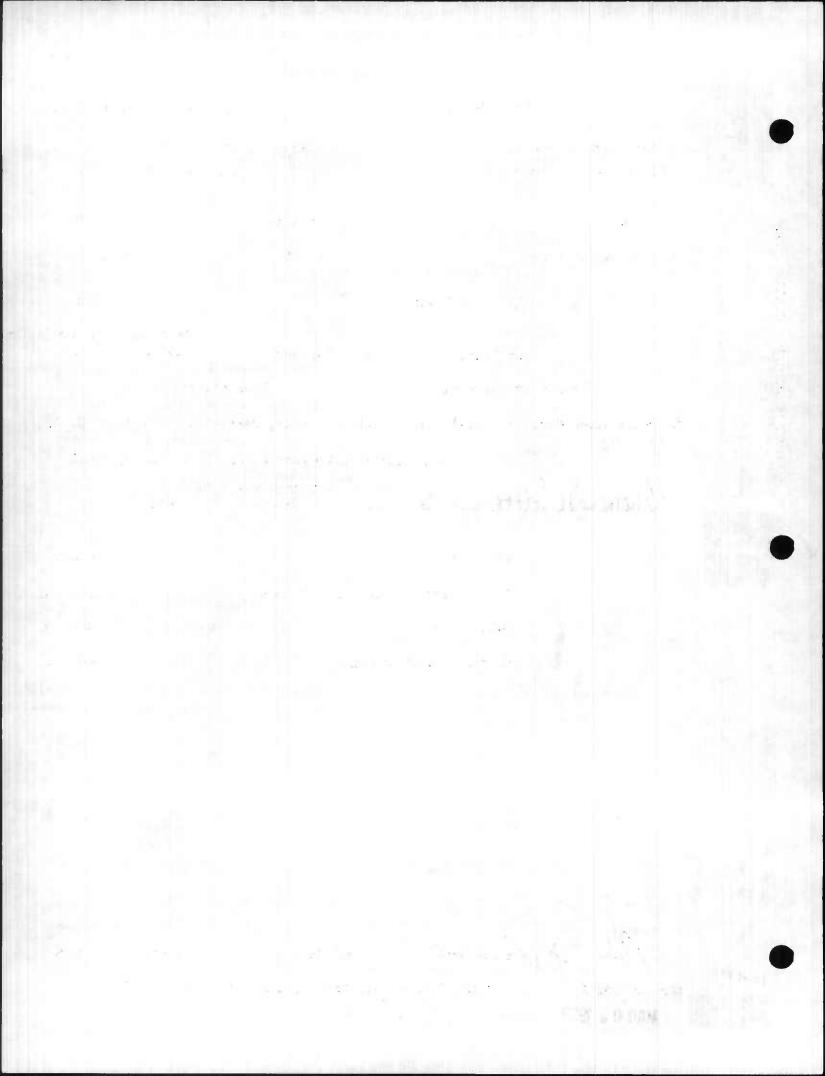
29a. Certifie

4 Homicide

(Check only

32. Registrar's Signatora

6 ☐ Could not be datarmined



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 1. Decedent's Nama (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Day March 2, 1999 Doris E. Cleveland 5:30 am 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Gladys Spellman Nursing Home Cheverly Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Year) 5. Sociel Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthdey) 1 M 2 X F Months Days 68 Yrs. 577-38-8517 Nov. 21, 1930 Washington, DC Usual Residence of Deceden 10b County 10c. City. Town or Location 10d, Inside City Limits 1 Yes 2 No Maryland | Prince George's Landover Hills 10f. Zip Code 10g. Citizen of What Country? 20784 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, 12. Was Decedent Ever in U,S. Armed Forces? Black, Whita, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Office Manager Retail 18. Mother's Name (First, Middle, Maiden Surneme)

the Marylend r 28a-f show "natural", or itema 23a or permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or flerma 23a and fujury or other traumatic event, the Med cal Examiner must energy.

Physician

/Medical

Examiner

10a State

Funeral

Director

Physician /Medical Examiner

the death certificate be executed physician and the burial-transit for use es 88 signed by the a

P.O. Box 68760. Records, Division of Vital or Attending Physician: Director: / Euneral Dire
 Funeral Dire
 Funeral Dire

within 2 To the I

Registrar

Certification: To

1 Yes 2 No

5 Pending

investigation

6 ☐ Could not be determined

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

29b. Signatu

4 ☐ Homicide

(Check only one)

31. Date filed (Month, Dey, Year)

Directo 10e. Street and Number 4405 73rd Avenue Funeral 11. Marital Status 1 Never Married 2 Married by 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) 17. Fether's Name (First, Middle, Last) William . Simmons Mildred Elizabeth Crowder 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Pnht) 3008 Enterprise Road, Mitchellville, Maryland 20721 Phyllis Green - Sister-in-law POA 20a. Method of Disposition 20b. Place of Disposition (Neme of cametery, cremetory or other place) Dete 20c. Location - City or Town, State 1 Burlat 2 N Cremation 3 Removal from State Metropolitan Crematory 03/03/99 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4739 Baltimore Avenue, Hyattsville, MD 20781 Approximete fnterval Between Onset and Death Immediate Cause (Finel Preumonia. disease or condition resulting in death) Due to (or es e consequenca of): Recurrent Examiner Cancer, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the ceuse of deeth?

Part fl. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No Cerebrovascular Accident 1/98, λq 24a. Was an eutopsy Completed Drstunction, Chronic Obstructive Lung Disease 25. Was case referred to medical examiner? Be

1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) Hospifal: 1 ☐ Inpatient 2 ☐ ER/Outpatienf 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 28a. Date of Injury (Month, Dey Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated.

29c. License number

end eddress of person who complete | urkearly 131001

and leause of deeth (Item 23e) (Type, Print) 7500 Green way Catr. I

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

29d. Date signed (Month, Day, Year)

32. Registrar's Signature

MAR 0 5 1999

A. 100 10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death

Funeral Director tha Meryland item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Medical Examinal must be not lied at with death Saltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after. Department of Health and Mental Hygiena. Introductant: If Item 27 is marked other than "naturel", or fielenty injury or other traumatic event.

Examiner physicien and the burial-transit certificete be axecu 89 950 to ed by the a P.O. signed by to Division of Vital Records, certificata hes or Attending Physician: after death. Director: After this certifica funeral

24 hours a Funeral D ompletely To the vithin 2 2 State Registrar

3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** Beatrice Loreathea Crutchfield 10:22pm February 27, 1999 4b. City, Town, or Location of Deeth 4c. County of Deeth 1999 /Medical 4e Fecility Neme (If not institution, give street end number) Examiner Prince George's Southern Maryland Clinton If Under 24 Hrs. If Under 1 Yeer Birthplece (State or Foraign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) Months Deys Hours 1 M 2 1 F 85 Yrs. 230-44-8651 June 20, 1913 Newport News, Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Maryland Prince George's Temple Hills Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3901 21st Avenue 20748 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Stetus Black, White, etc. 1 Never Married 2 Married 1 Yes 2√ No Specify: Black. à 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Private/ DC GOVT. ENTREPRENEUR/ TEACHER 18. Mother's Nama (First, Middla, Meldan Sumeme) 17. Fether's Neme (First, Middle, Last) Be James Wilson Ida Jackson 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print)grandson #304 Upper Marlboro, MD 20774 D. Fields, Jr. 9605 Lake Point Ct. William 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 3/6/99 Suitland, Maryland 4 □ Donetton 5 ♥Other (Specify)Entombment Cedar Hill Cemetery 22. Name end Address of Fecility Marshall's Funeral Home of MD 21. Signature of Funerel Service Licenses 23a. Part1. Enter the disease, or complications that caused the death shock, or heart feilure. List only one cause on each line. Suitland, MD 20746 Approximeta Intervel Between Onset end Deeth Physician /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) hu ecomponistes Examiner brilletia antri cular Sequentielly list conditions, if eny, leeding to immediate causa. Entar Undarlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest Due to (or as e consequence of): d'isea arten Physician/Medical Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert II. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Ware eutopsy findings eveileble prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? Completed 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only ona) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatiant 2 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 27. Menner of Deeth 28c. Injury et Work? Certification: 1 Naturel 5 Panding Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At homa, farm, streat, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, daeth occurred et the time, date and place, end due to the ceuse(s) and manner es steted.

2 Medical Examiner: On the basis of exeminetion and/or investigetion, in my opinion, death occurred et the time, date and place, and dua to the causa(s) and mennar stated. 29a. Cartifier Medical (Check only one) 29d. Date signed (Month, Dev. Year) 29b. Signature end title of certifier 29c. License number 45435 30. Name end eddress of person who completed cause of death (Itam 23a) (Type, Print)

SOUTHERN

MAHEW

32. Aegistrer's Signeture

Maryland Hospita

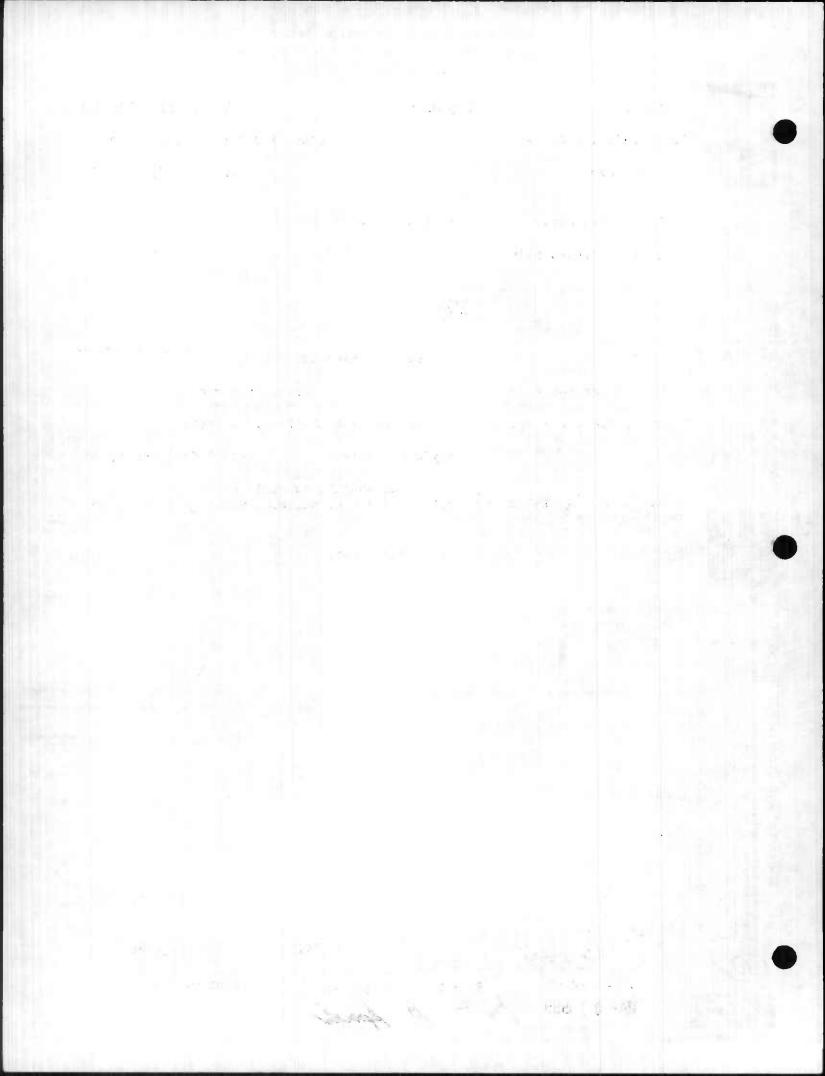
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State of Maryland / Department of Health and Mental Hygiene

		1. Decedent's Nama (First, Middla, Last)					Death	2. Date of Dea			ime of Death
Physician /Medical	_	Edward R	C	arpen	ter			Februar	y 23 1	Year 999 1:	20am
Examine	r 4		acility Nama (If not institution, giva street end number)					cation of Death			
		22726 Fairview Drive					Long View		St. Ma	-	
Funeral Director	5. Social Security Number 237-34-9029 6. Sex 73 Yrs. Fig. (In yrs. lest birthday) 1 Under 1 Year 1 Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 26, 192							26, 1925	9. Birthplace (3 Country) NC	Stete or Foreign	
show	Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location							10d. Insida City Limits 13€ Yas 2 □ No			
28a-f	MD St. Marys Long View Beach 10e. Street and Number 10f. Zip Coda 10g. Citizen of Wh 22726 Fairview Drive 20621 USA 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 No 11. Nevar Married 2 Married 2 Married 1 Nevar Married 2 Married 2 No 15 No 16 No 17 No 18										
23a or	rai Dir	22726 Fairview				20621			USA		
within 72 hours after death with the Maryland ene. then "patural" or items 23e or 28e-f show the Madical Evaluation must be notified at ampliabled by European Discotory.	2	1. Marital Status 1. Nevar Married 2. Married 3. Widowed 4. Divorced	12. Was Decedent Armed Forces? 1 2 Yes 2 1 If Yes, Give Year or Datas:	1944		Dacedent of specify Cut es 2 No	Hispanic Origin? (Special, Mexicen, Puarto Specify:	ecify Yes or No- Rican, etc.)	Blac	e - Amarican ind k, White, etc. "Black	ian,
d 2 should be filled within 72 hours at the and Mentel Hyglene. 7 is marked other than "natural", or traumatic event, in a Madical Example To Re Commission hy is	Completed	15. Decedent's E (Specify only highast gi	ducation eda com <i>pleted)</i> College (1-4or 5)+)			ipation a during most of working ad)	ing		usiness/Industry	+
filed with Hygiena. ort, the		12th 7. Father's Name (First, Middle, Las	t)		Housing	Inspe	ctor	(First, Middle.	D.C. Government		
should be filed and Mentel Hygi marked other imatic event, T. Re.	0	William Carpent								,	
d 2 should be filed the marked other traumatic event,		19a, Informant's Name/Relationship			19b. Malling Ad	dress (Stree	Carrie Ca			State, Zip Code,)
	7	Chelma Carpenter	- Wife		P.O. Box	188	Chaptico,	MD. 206	521		
of H	2	Oa. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 [4 ☐ Donation 5 ☐ Other (Spec		20b. Pla cer Mary	ica of Disposition metery, cremator land Vet	(Neme of y or other pla cerans	ace)	Date 3-1-99 (20c. Location - Cheltenh	City or Town, Si	ata
Page Manuit. Page		21. Signature of Funeral Servica Lica 23a. P rth Enter the disease, of corshick or heart failure. List only	mplications that caused one causa on each li	ne.	Mars 421 Do not enter the	shall' 9th. mode of dy			gton, D.	Onse	el Between at and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) Metastatic Bladder Cancer Due to (or es a consequence of):								8 mo	nths
ficate be executed g physician and as the buriel-transit	CXamin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence or Injury that initiated events Due to (or as a consequence or Injury that initiated events					of):				
= 06	2	hat initiated events resulting in death) Last	Due to (or as a consequence of):								
death carti		Part II. Other significant conditions	contributing to death b	ut not result	ting in the under	don cause o	iven in Part I	23h Did	obacco use co	ntribute to the o	ause of death?
as that the death cartigned by the attending be deteched for use.		an it. Other significant conditions	contributing to death o	at not resum	ang in the under	ying cause g	WOTENT GIVE.		Yes 2□ No	3☑ Probably	
The law requires that the death cartale has been signed by the attending page 2 should be datached for use	d palaid							24a. Was perfo	an autopsy med?	24b. Wera au avalleble completi of death'	prior to on of cause
The la								10	res 2 No	1 ☐ Yes	2 No
(D (C.	0	25. Was case referred to medical examiner?					26. Place of Deat	h (Check only o	ne)		
(D (C.	3	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital:			LI DOA			lenca 8 Oth		
hysician: his certifica si director, p			the state of the s				Injury at Work? 28d. Describe how Injury occurred 1 1 Yes 2 □ No				
Physician: this certifica and director, p. To Re C		1 ☑ Naturai 5 ☐ Pending						28f. Location (Street end Number or Rural Routa Number, City or Town, State)			
anding Physician: arth. After this certificate the funeral director,		1 ☑ Natural 5 ☐ Pending	be 28e. Plece of Inj	ury - At horr c. (Specify)	ne, farm, street, f	actory, office		City or Tox	m, State)		
anding Physician: arth. After this certificate the funeral director,	Certifications	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Pending investigation of Could not determine	be 28e. Plece of Inj	of my knowl	·: ledge, deeth occ	urred at the t	time, date and place,	City or To	m, State) cause(s) and ma		ause(s)
anding Physician: arth. After this certificate the funeral director,	redical Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 1 Pending investigatio 6 Could not determine	28e. Plece of Injuding, etc. building, etc. bysician: To the best miner: On the basis of	of my knowl	·: ledge, deeth occ	urred at the t lation, in my	time, date and place,	City or To	m, State) cause(s) and madete end plece,		
Hospital or Attending Physician: '4 hours after death. Funeral Director: After this certificately filled in by the funeral director. To Ref.	Medical Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) Clock Signature and title of pertifier	28e. Plece of Inj building, et hysician: To the best miner: On the basis of and manner sti	of my knowl examination	ledge, deeth occ on end/or Investig	urred at the tration, in my	time, date and place, opinion, death occurr	City or To	m, State) cause(s) and madete end plece,	and due to the c	
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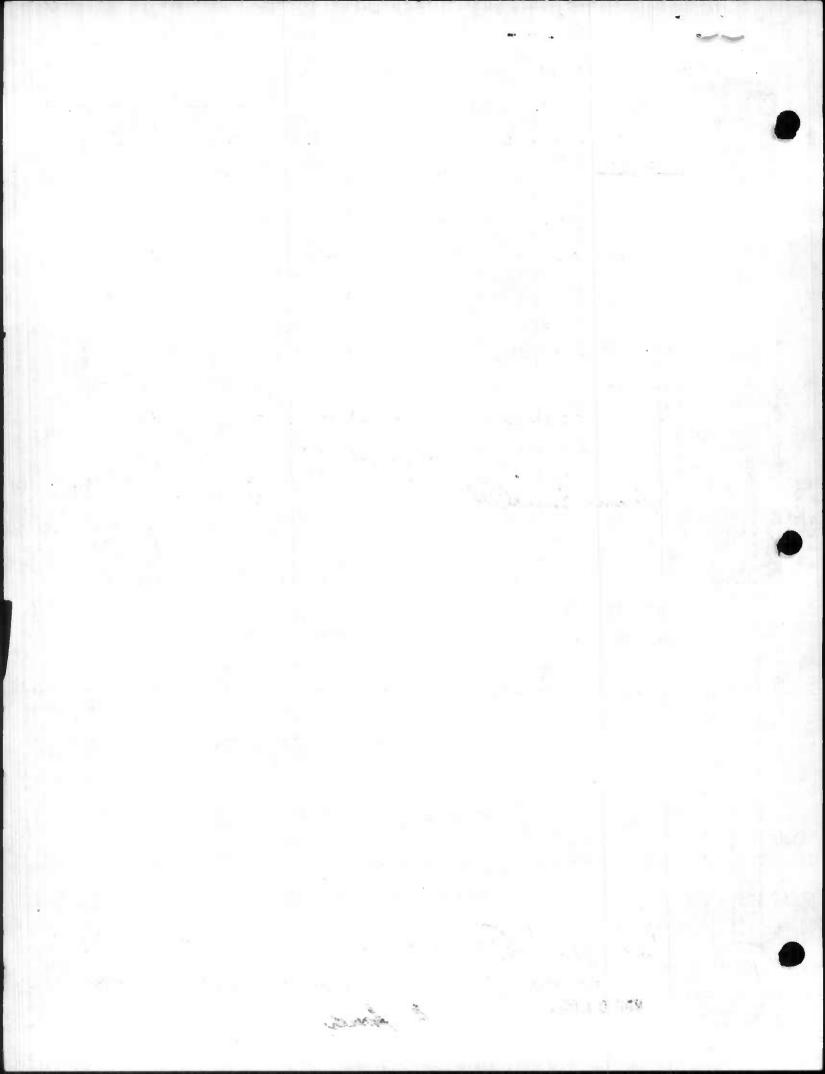


State of Maryland / Department of Health and Mental Hygiene 0

Item: 5 per F.H G-769 3/19/99 reb Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 24, 1999 **Physician** Month Johnnie P. Collins February 8:15 AM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 17103 CLAIRFIELD LN UPPER MARLBORO PG 7. Aga (In yrs. last birthday) If Undar 1 Yaar 5. Social Sacurity Number If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 6/19/19 **Funeral** Birthpiaca (Stata or Foraign Country) 1QM 20F Days Yrs. 79 Director Usual Rasidance of Decedant 10a Stata 10b. County 10c. City, Town or Location 28a-f show 10d. insida City Limits must be notified at Director 1 Yas 2 □ No DC N/A WASHINGTON the 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 6 Itams 23a 2601 MONROE ST NE 20018 USA Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1∑ Yas 2 □ No If Yas, Giva Yaar or Datas: 11. Marital Status 14. Race - Amarican Indian, Black, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yas 2X No Specify: Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorcad Completed 15. Decedant's Education (Spacify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry el Hygiene. Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12 YEARS NONE SECURITY OFFICER SECURITY 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Surnama) . Peges 1 and 2 should be fill ment of Health and Mentel Hant: If Item 27 is marked oth lury or other traumatic even Be JOHN E. PAYDEN ROXIE COLLINS ROBERSON C 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) MARLENE MANNING (DAUGHTER) 7309 POWHATAN ST, LANHAM, MD., 20706-1233 10 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of 20c. Location - City or Town, Stata TRAVERLERS REST CHURCH CEMETERY 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Spacify) BAPTIST 373/99 permit. Pege Department of Important: If any injury or once. FAIRMONT, SC 21. Signature of Funeral Service Licenses JOHN T. RHINES CO., INC. 3030 12TH ST NE, DC 20017 Perti. Enter tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, mock, or heart failura. List only one cause on each line. Approximata Onsat and Death **Physician** /Medical Immediata Causa (Final PANCREATIC CANCER disaasa or condition rasulting in daath) Examiner Examiner ADENOCARCINOMA OF THE PANCREAS, STAGE IV siclan and bunal-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initialed avants rasulting in daath) Last Dua to (or as a consequence of): P.O. Box 68760, physician s the burial Physician/Medical Dua to (or as a consequence of): use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown COPD Records, À page 2 should be Completed 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? PERIPHERAL VASCULAR DISEASE peen certificate has 1 Yas 2 No 1 ☐ Yas 2 ☐ No Vital or Attanding Physician: Be 25. Was casa rafarrad to medical axaminar? 26. Placa of Daath (Check only ona) Hospital: 1 ☐ Inpatlant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 6 Mothar (Specify) Relative's 1 Yas 2 No Certification: To of this 27. Mannar of Death 1 Natural 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred After t 28c. Injury at Work? 5 Panding Invastigation Division death. 1 ☐ Yas 2 ☐ No s efter death the 2 Accidant 6 Could not be 3 Suicida I in by t 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida To the Hospital
within 24 hours e
To the Funeral C Hospital Medical 29s. Certifie 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Or the bast of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. (Check o 29b. Signature a 29d. Data signed (Month, Day, Year) difficulties of certifier 29c. Licensa number Feb. 25, 1999 MD 30361 complated causa of daath (Itam 23a) (Type, Print) 30. Nama and address of person 6525 BELCREST ROAD, SUITE #500, HYATTSVILLE, MD MAGERY MYERS, MD 32 Registrar's Signatura State bonds Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

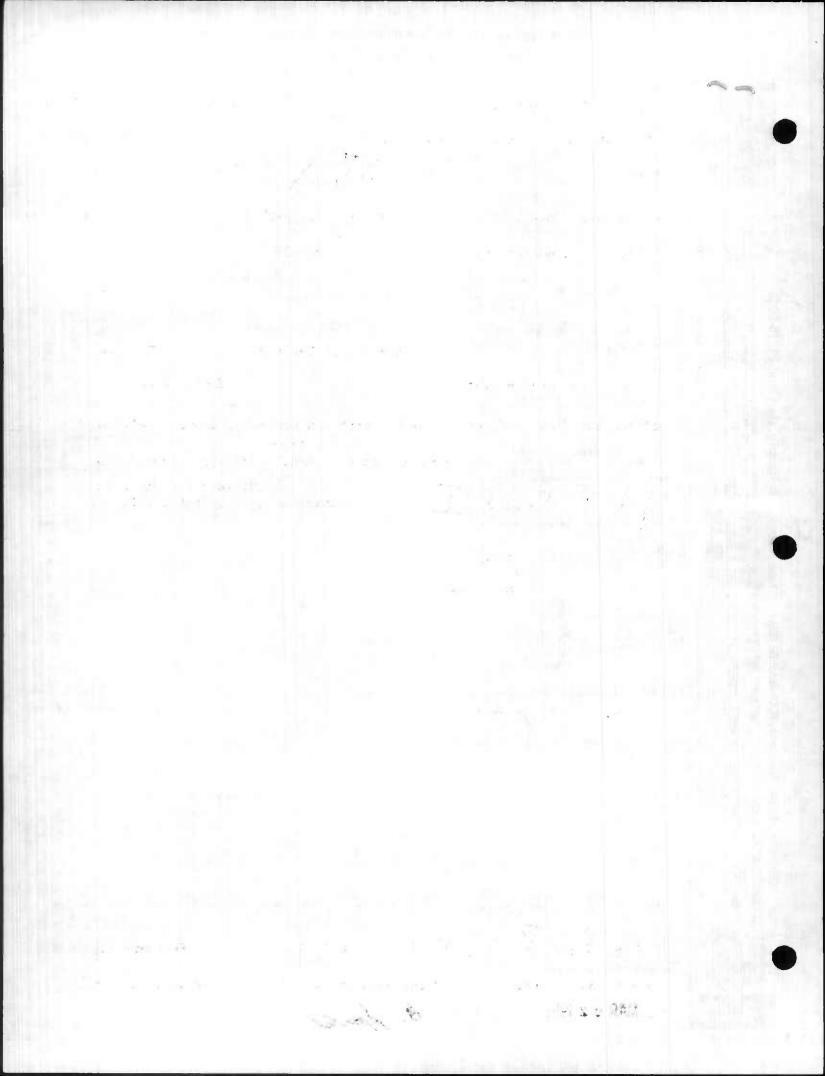
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 10 Physician Birdie G. Campbell 7:55PM /Medical 4b, City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street end number) Examiner St. Thomas More Nursing & Rehab. Center Hyattsville Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth March 30 1903 Birthplace (State or Foreign Country)
 Kansas 7. Age (In yrs. lest birthday) **Funeral** 1□M 2□F 578-20-0636 95 Yrs. **Director** Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Maryland Prince George's Directo Capitol Heights 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? With r than 'natural', or items 23s or the Medical Examiner must be r 20743 4307 North Addison Road United States permit. Pages 1 end 2 should be filed within 72 hours after deeth. Department of Haalth end Mental Hygiena. Important: If flem 27 la marked other than "natural", or flems 23s any injury or other traumatic avent the Funeral 14. Race - American Indien, Bleck, White, etc. 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Maritai Status 1 Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Negro Baltlmore, Maryland 21215-0020 py 3 ₩ Widowed 4 Divorced Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondery (0-12) College (1-4or 5+) Substitute Teacher Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Kelly Boydston Mattie Pitts 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Colleen Boydston - Niece 4307 North Addison Road, Capitol Heights, MD 20743 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Park 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 2/15/99 Maryland National Mem. Laurel, MD 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Pneumonia Examiner Due to (or as a consequence of): Examiner Dementia physician and the buriel-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of): SE esn 0 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Seizure: heart failure Division of Vital Records, by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of deeth? pege 2 has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificete Hospital or Attending Physician:
 24 hours after deeth.
 Funeral Director: After this certifical 25. Was cese referred to medical exeminer? director Be 28. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Naturat 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, and due to the cause(s) and manner as stated. pmpletaly (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my optnion, death occurred at the time, date and place, end due to the cause(s) end manner stated. within 2 To the # 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 10 Mensien D22708 February 16, 1999 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Meer Saiid Zonozi 1328 Southern Ave., S.E. #307; Wash., D.C. 32 Registrar's Signeture

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Adolphus Chastine February 1999 4:31PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince George's 6. Sex 10 M 2 F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 13, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Yrs. 403-50-1521 60 1939 Kentucky **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Manyland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or flams 23a or 28e-f show any injury or other traumatic avent, the Mexical Evantment must be routified as 10d. Inside City Limits 10b. County 10c. City, Town or Location Maryldn Prince George's Clinton 1X Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9004 Tocca Drive 20735 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Contract Officer Government 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Be Herman Chastine Ethel Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Miriam Chastine - Wife 9004 Tocca Drive, Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 3/4/99 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home would 4001 Benning Rd., N.E. Wash., D.C. 20019 There the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Phenmonia Examiner Due to (or as a consequence of): Examiner Multiple CVAs The law requires that the death certificate be executed physician and s the buriel-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Stoge Ren Physician/Medical Due to (or as a consequence of): Years Hypertension signed by the all Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of ceuse of death? 24e. Wes en eutopsy performed? Completed r this certificate has 1 ☐ Yes 1 Yes I or Attending Physician: efter death. Director: After this certifica 25. Wes cese referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2N No 10 Inpatient 2 ER/Outpatient 3 DOA funeral Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 28b. Time of 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide filled in 24 hours Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and menner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 ho To the Func completely f (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00052865 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) K. Michael Figaro - 6580 Braddock Road, Alexandria, VA

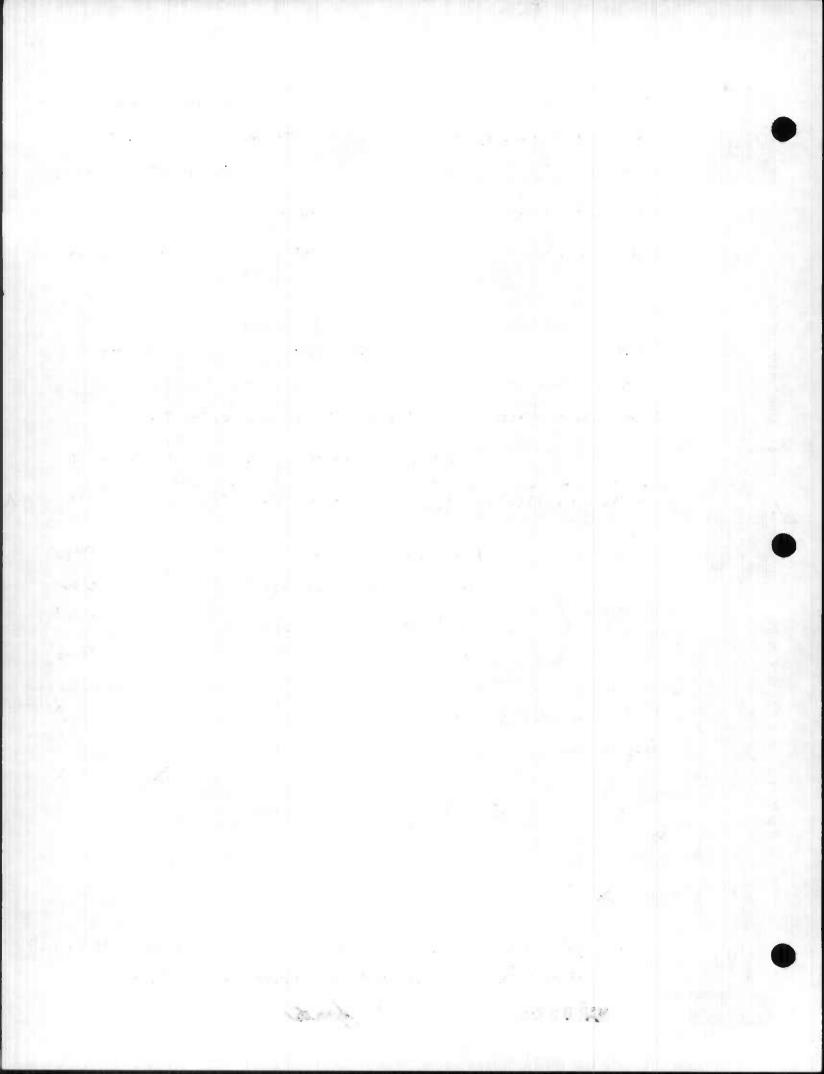
32. Registrar's Signature

DHMH 16 Rev 6/95

Registrar

31. Date filed (Month, Day, Year)

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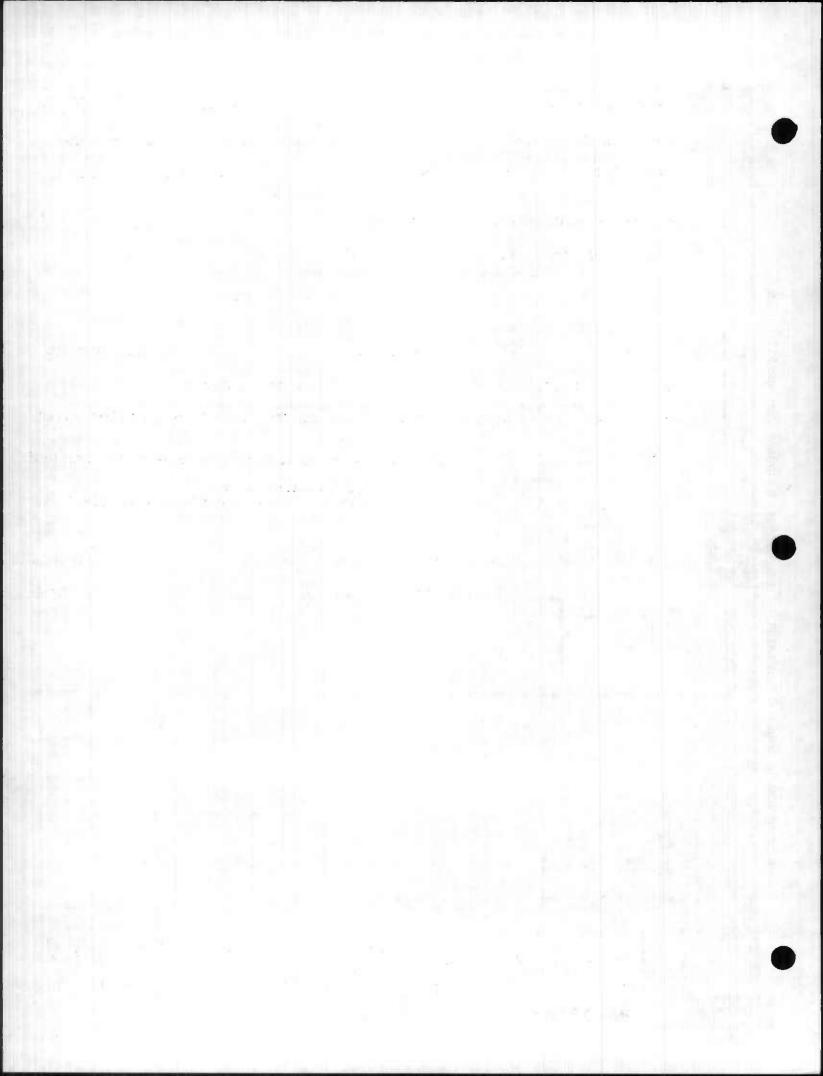


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State of Maryland / Department of Health and Mental Hygiene 9

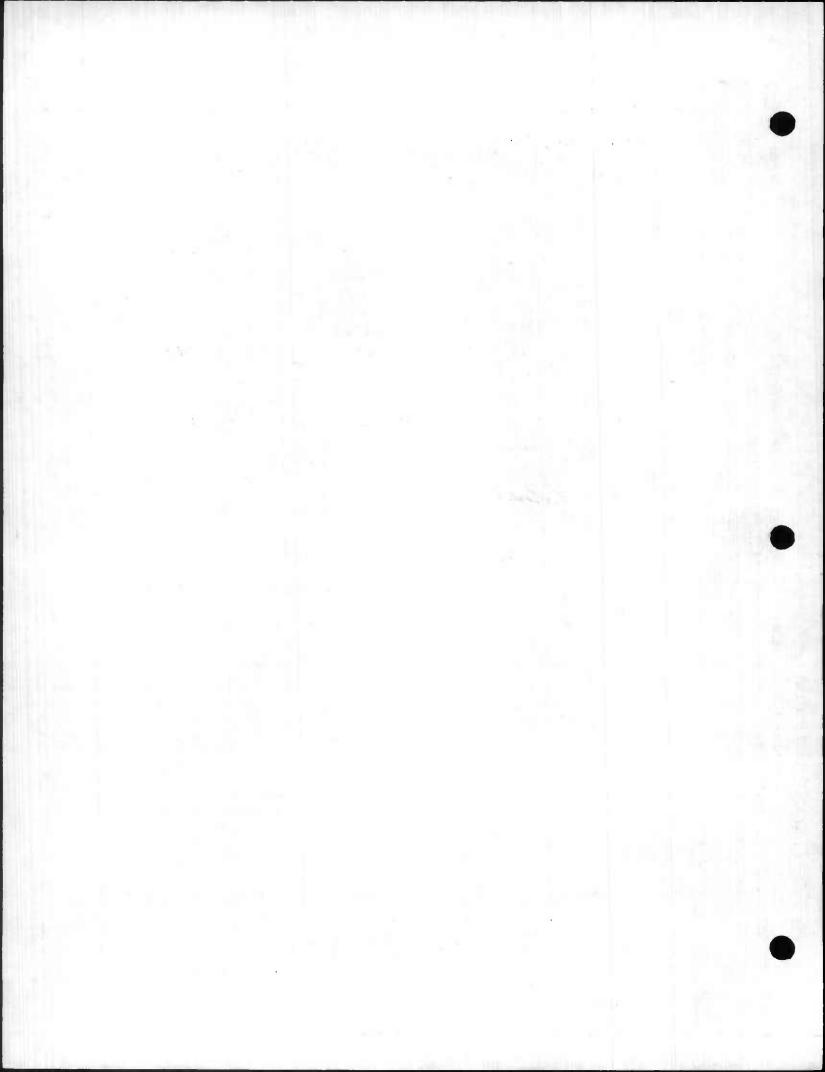
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	_	Decedent's Name (First, Middentification)	llo (get)		Cer	tificate of	Death		2. Date of De	Reg. No.		3. Time of Death
	Physician /Medical	Dorothy Jean (Month March				04 1999 8:20q				
狙	Examiner	4a Facility Neme (If not institution 16934 Strawber		4b. City, Town, or Location Hagerstown			Washington Co		-			
	Funeral Director	5. Sociel Sacurify Number 238–44–7579	6. Sex 1	7. Age (In yrs.	last birthday) 66 Yrs.	If Under 1 Year Months Deys		Min.	8. Dete of Bir (Month, De Mar. 9,	1932	9. Birthp Cour Ar	lace (State or Foreign try) Kansas
pug	*	Usual Residence of Decedent 10a, State 10b, Count	,	10c. City	y, Town or Lo	cation					1	0d. Inside City Limits
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, Mary	Ith and N	19a. Informant's Name/Ralation Joseph Wendell		sband		g Address (Street Strawbe						
Baltimore,	Department of Health Important: If Item 27 (any Injury or other transce.)	20a. Mathod of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		State	emetery, cren	sition (Name of natory or other pla wn Memor		ark N	Dete	20c. Location		wn, State Maryland
Baltimor	Departman Important: any injury pncs.	21. Signature of Funeral Servica Licansee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland										
cardificeta be executed	ending physician and ruse as the buriel-transit and leading an Medical Examiner	23a. Part1. Enter the disease, or shock, or head/failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or Injury that Initiated events resulting in death) Last	a	liver Dua to (o Dua to (o		uance of):	sta			M		Approximate interval Between Onset and Death 26 months 26 months
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	State Registrar	31. Data filad (Month, Day, Year MAR 0 8	1999	Begistrar's Signa	tura G.	Spark	2	HO	1	0	<u> </u>	- Larrate



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/Medical		Ann CHAP		41 O'S Town and		March 7 19		0022			
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Funeral	5. Social Security I		Sex 7. A I□M 2∇ F	ge (In yrs. las	Mc	Under 1 Year onths Deys	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De	th y, Year)	9. Birthp	place (Stete or Fo
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P o	11 Burial 2	Cremation 3	Removal from State	COM	etery, cremetor	y or other ple	ce)	Date	200. Location	1- City of 10	JWII, State
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Important: if item 27 in any injury or other tra ance.	21. Signature of Fr	21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Minnich Funeral Home									
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	23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between										
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MARCH **Physician** 8:03AM Addie Viola Cornelius 6 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DEFMAN NURSING HOME Hagerstown Washington County If Under 24 Hrs. If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Feb. 14, 1902 West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours 1□ M 2XF 236-36-1276 97 Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show Maryland Washington Co. Hagerstown 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 1304 Pennsylvania Avenue 21742 USA 234 Funeral Nome : 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married White "natural", or 21215-0020 1 Yes 2 No Specify: Specify: 20 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filled within 72. Department of Health and Mental Hygiene. Important: if them 27 is marked other than "netueny or other traumatic even." Elementary/Secondary (0-12) College (1-4or 5+) Clerk Tire Company 8 0 Baitimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sommers Hayes Watring Sarah Mackimey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) W. Merle Cornelius, Jr./Son 13526 Spriggs Road, Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematory Mar. 6 Smithsburg, Maryland 21. Signature of Funeral Service Licer 22. Name and Address of Facility Douglas A. Fiery Funeral Home the 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 ors that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): 68760 Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? disease 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 20 No 1 □ Yes 2 □ No Vitai 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Detatural 5 Pending n 24 hours after death. Ne Funeral Director: After pletely filled in by the fur 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral Di completaly filled in

State Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30 Name and address of person the completed cause of death (Item 23a) (Type, Print)

AMUEL CHAN M.D. 1185 M+ A

32. Redistrar's Signature

CHAN

MAR 0 8 1999

DHMH 16 Rev 6/95

(1)

0 A

AME KNOWN

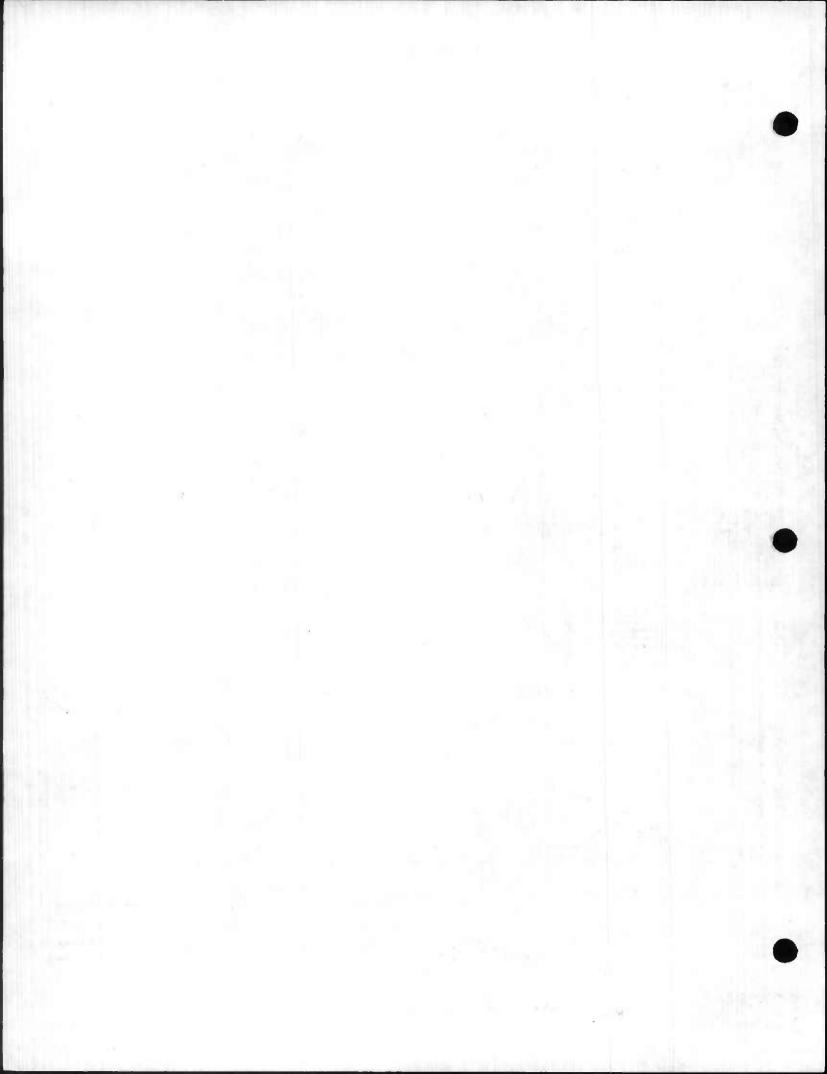
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Rd. HAGERSTOWN, MD 21740



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Evelyn Frances 7:20 A.M. Clark 1999 March 6 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth 13302 Hunter Hill Drive Apt. C Hagerstown Washington If Under 1 Year 5. Sociel Security Number 8. Date of Birth (Month, Dey, Yeer) 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 1□ M 2♥ F Deys Hours Min. 90 Yrs. 214-09-9501 May 10,1908 Maryland Usual Residenca of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 13302 Hunter Hill Drive Apt. C 21740 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ō No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: 3Å Widowed 4 □ Divorced Specify: White 15. Decadent's Education (Specify only highest grede completed) 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Bueiness/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8 Retail Dept. Store Secretary 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) George Washington Churchey Fannie Frances Elizabeth Lewis 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Paul J. Armstrong/Grandson 336 Belview Avenue Hagerstown, Maryland 21742 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete XXBuriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) View Cemetery 3-9-99 Sharpsburg, Mary land 21. Signature of Funeral Service Ligans Osborne Adress Facility Home 425 S. Conococheague St.Williamsport, MD 21795 Enter the divisese, or complications thet caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, or heart fallure. List only one cause on each line. Approximate Intervel Between Onset end Deeth Immediete Ceuse (Final Cancer of Uncertain Origin diseese or condition resulting in deeth) months Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of) Due to (or es e consequença of) 23b. Did tobecco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveileble prior to 24e. Wes an eutopsy performed? completion of cause of deeth? 1□ Yes 20 No 1 ☐ Yes 2 ☐ No 26. Piece of Deeth (Check only one)

Physician /Medical Examiner

Examiner

Completed by Physician/Medical

Be

Medical Certification: To

Physiclan

/Medical

Examiner

Funeral Director

by

Completed

Be

2

10e. State

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic acceptance.

Division of Vital Records, P.O. Box 68760, ettending physician for use as the buria The law requires that the death certificate be or Attending Physician: director, this After thi ofter death.

Director: Aft
d in by the fur

Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. History of Breast Cancer Hypothyooidism 25. Wes case referred to medical examiner? Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28b. Time of Injury 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 26d. Describe how injury occurred 5 Pending Investigation 1 Neturel 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number

State Registrar

MAR 0 8 1999

31. Dete filed (Month, Dey, Year)

32. Registrer's Signature

Cynthia Kutther - Sand, mo

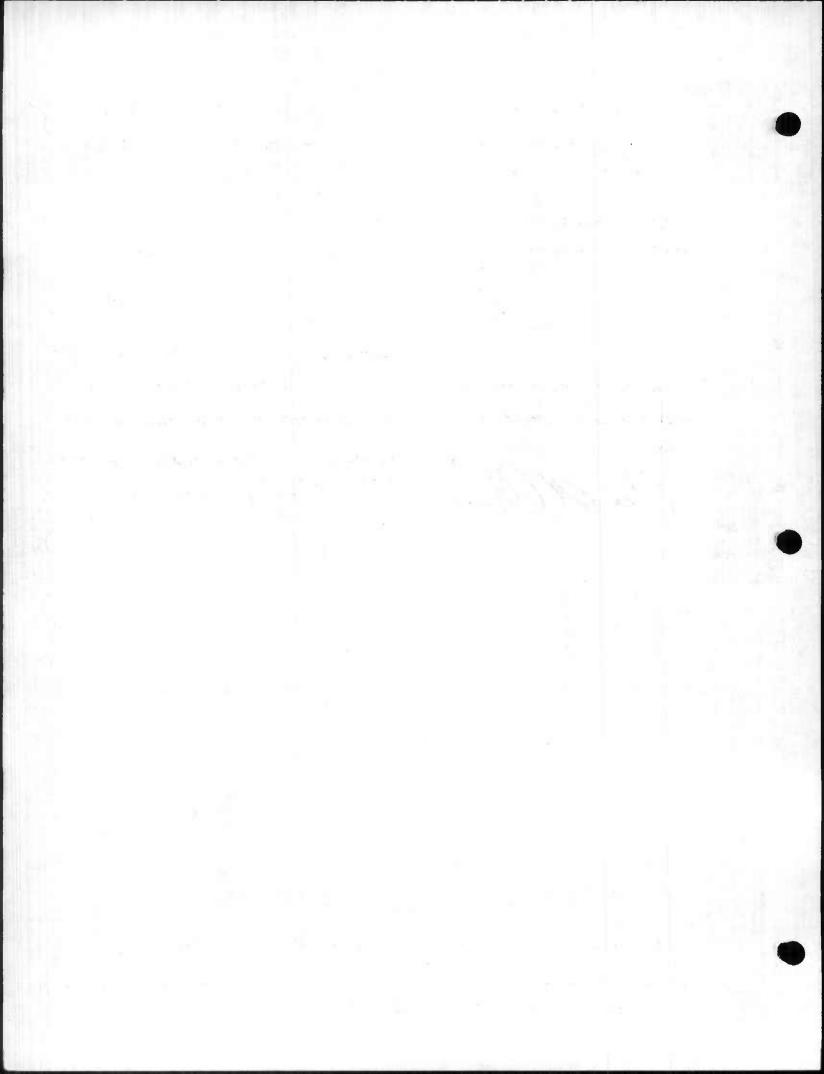
30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

March 8, 1999

Cynthia Kuther-Sands, mo 11110 Medical Campus Rd Hagerstown, Maryland

21742

To the Hospitai o within 24 hours eff To the Funerai Di completaly filled is



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 05 Day **DEEMS** MISTER BERDYE 1999 March 7:28 pm 4a. Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Cambridge Chesapeake Woods Center Dorchester If Under 1 Yaar If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 10 M 201 Days 213-03-3948 Yrs. 1907 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Cambridge MD Dorchester 1 ☐ Yes 2 ☐ No 10f. Zip Code 21613 10g. Citizan of What Country? U.S.A. 10e. Street and Number 525 Glenburn Ave. 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give Yaar or Datas: 11. Maritai Status Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: white 3 Widowed 4 □ Divorcad 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) bookkeeper state roads commission 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Pear1 Isaac Spry Moore Inslev 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 525 Glenburn Ave., Cambridge MD 21613 Mrs. Wilsie Mullin - sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Buriai 2 Cremation 3 Removal from State 3-9-1999 Baltimore MD 4 □ Donation 5 □ Other (Specify) Loudon Park Cemetery 21. Signature of Funarei Service Licensee 22. Name and Addrass of Facility Thomas Funeral Home PA 23a. Part1. Enter the disaasa, or complications that caused tha death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 700 Locust St. Cambridge MD 21613 Approximete intervel Between Onsat and Death Cardio-Vascular Disease Immediate Causa (Final disease or condition resulting in death) 15 years Due to (or as a consequenca of) Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Diseese or injury that initiated avants resulting in death) Last Due to (or as a consequenca of): Dua to (or as a consequence of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Susease 24b. Were autopsy findings evailable prior to 24a. Was an autopsy performed? completion of cause of deeth? 1 ☐ Yes 2 XNo 1 ☐ Yes 2 ☐ No 26. Plece of Death (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

Physician /Medical Examiner The law requires that the deeth certificate be executed

Physician

/Medical

Examiner

10a Stata

Funeral

Director

"natural", or items 23s or 28a-f show idical Examiner must be notified at

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Records,

Division of Vital

Hospital or Attending Physician:

pormit. Pages 1 and 2 should be filed within 72 Department of Health and Mantal Hygiene. Important If Nem 27 is marked other than "natus any injury or other traumatic event."

Director

Funeral

by

Completed the Medical

Be

physician end the buriel-trensit should be deta pege 2 director, this funeral After after deeth.

Director: A
d in by the f To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b

Physician/Medical ģ Be Completed Certification: To

Examiner

Medical

29e. Certifier

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death

1 Natural 5 Pending 2 Accident 3 Suicide 4 Homicide

Investigation 6 Could not be determined

28b. Tima of

28c. Injury at Work? 28a. Place of injury - At home, farm, street, factory, offica building, etc. (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, Stete)

29b. Signature and title of cartifier Caman 29c. License number 214349 29d. Date signed (Month, Dey, Year)

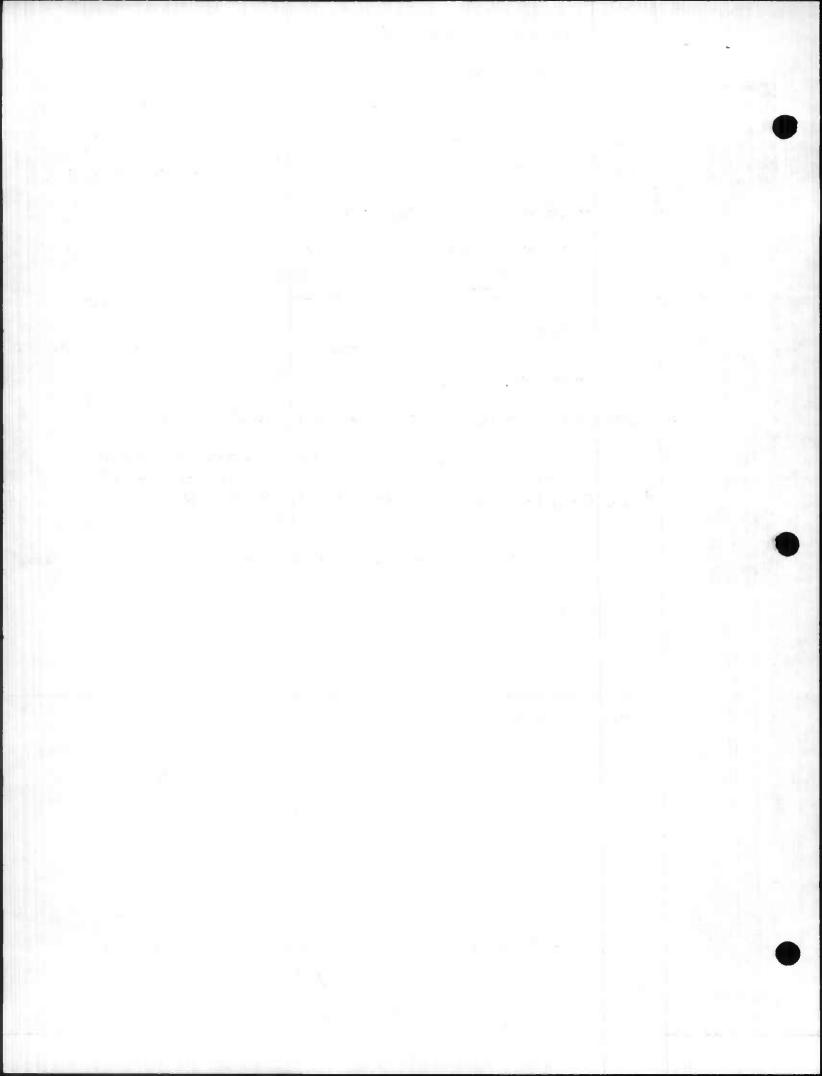
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 Franklin St. Cambridge, MD 21613 yup Tanman M.D.

31. Date filed (Month, Day, Year) MAR 0 8 1999

32. Registrar's Signature

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner es steled.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 3. Tima of Death 2. Date of Deeth Month **Physician** LAURA LOUVENIA DYSON March 6, 1999 12:00PM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Civista Medical Center La Plata Charles If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Days Hours Min. (Month, Day, Year)

June 25, 1923 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthpleca (Stete or Foreign Country) **Funeral** 1 M 2 F Months 229-26-1262 75 Yrs. Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director MD Charles La Plata 28a-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 7800 Mason Springs Road or Items 23s 20646 USA Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?

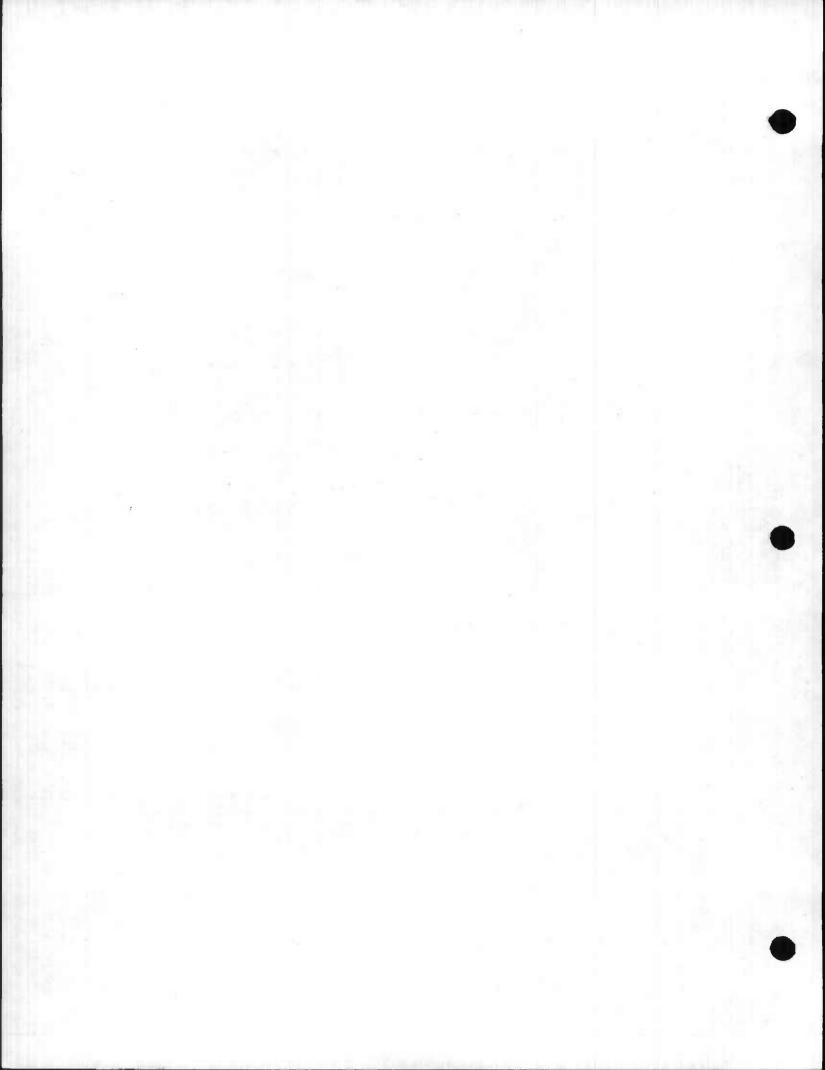
1 Yes 2 No
If Yes, Give
Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 243 Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be lited within 72. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "nath any Injury or other traumatic event, the Medica once. Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Richard N. Bowie Nora Elizabeth Posey Bowie 19e. Informant's Neme/Relationship (Type, Print)
Thomas B. Dyson/Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 7800 Mason Springs Road La Plata, MD 20646 20a. Method of Disposition
1 DaBurial 2 Cremetion 3 Removel from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Nanjemoy Baptist Cem. 3/10/99 Nanjemoy, MD 4 Donetion 5 Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name and Address of Fecility AREHART-ECHOLS FUNERAL HOME P.A. M00945 4 P.O. BOX 567 LA PLATA MD 20646 23a. Part1. Enter the disease, or complications that ceused the death. Do not e shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) andras arres Examiner Due to (or as a consequence of): Examiner terioschenter Cardio vascular physicien end s the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, direc Physician/Medical Due to (or es a consequence of): signed by the al Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ Completed 24b. Were autopsy tindings available prior to 24a. Was an sutopsy performed? completion of cause of death? pege 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate of Vitai Hospital or Attending Physician: 124 hours after death.
 Funeral Director: After this certificalety filled in by the funerel director. 25. Wes case referred to medical 89 26. Placa of Death (Check only one) Hospitaf: 1 Nnpetient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Tima of 28d. Describe how injury occurred 28c. Injury et Work? Division 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. edicai 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier D11176 March 8,1999

State Registrar

31. Date filed (Month, Day, Year) MAR 09 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arthur O. Wooddy 100 Washington Ave. P.O. Box 430 La Plata, MD 20646



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) ^{Day} 1999 **Physician** Mary Elizabeth Dickens March 8, 3:35 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 25260 Budds Creek Road Chaptico St. Mary's If Under 1 Yaar | If Under 24 Hrs. 5 Social Security Number 6 Say 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 KF Months Days Hours Yrs. 214-52-4000 49 Maryland Director October 28,1949 Usual Residence of Decedent with the Marylence 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified as 1 Yes 2 XNo Directo Maryland St. Mary's Chaptico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25260 Budds Creek Road 20621 U.S.A. death Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) permit. Pages 1 and 2 should be filed within 72 hours effer a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any injury or other traumatic event. 1 □ Navar Marriad 2 □ Married Maryland 21215-0020 1 Yes 2 No Specify: þ 3 N Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Spacify only highast grada completed) Elementary/Secondary (0-12) College (1-4or 5+) 10th Owner/Operator Night Club 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Be Joseph Thomas Butler Agnes Lucille 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Pamela Reed/Daughter P.O. Box 234, Chaptico, MD 20621 Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burlal 2 ☐ Cremation 3 ☐ Removal from State Charles Memorial Gardens 3/13/99 Leonardtown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 low 23a. Part 1. Enter the disease, or complications that caused the death. So not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Physician /Medical Immadiate Cause (Final disease or condition resulting in death) Examiner Examiner physician and s the bunal-trans Sequentially list conditions, if any, leading to immadiete cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last P.O. Box 68760 Physician/Medicai Due to (or as USB 85 1 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Records, þ 24b. Were autopsy findings Completed 24a. Was an autopsy performed? available prior to completion of causa of death? page 2 NA hes 1 Yas 20 No certificete 2□ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)
Injury at 28d. Describe how injury occurred Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P. 1 ☐ Yes 2 ☐ No After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 1 Netural 5 Pending efter death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner es stated.

The dical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and mannar stated. edicai 29a. Certifier To the To the To the 29b. Signature and title of certit 29c. License number 29d. Date signed (Month, Day, Year) March 8, 1999

completed cause of death (item 23e) (Type, Print)

32. Registrar's Signature

Jenewa

Hollywood, MD 20636

Hatrick Jarboe, MD

State

30. Name and and

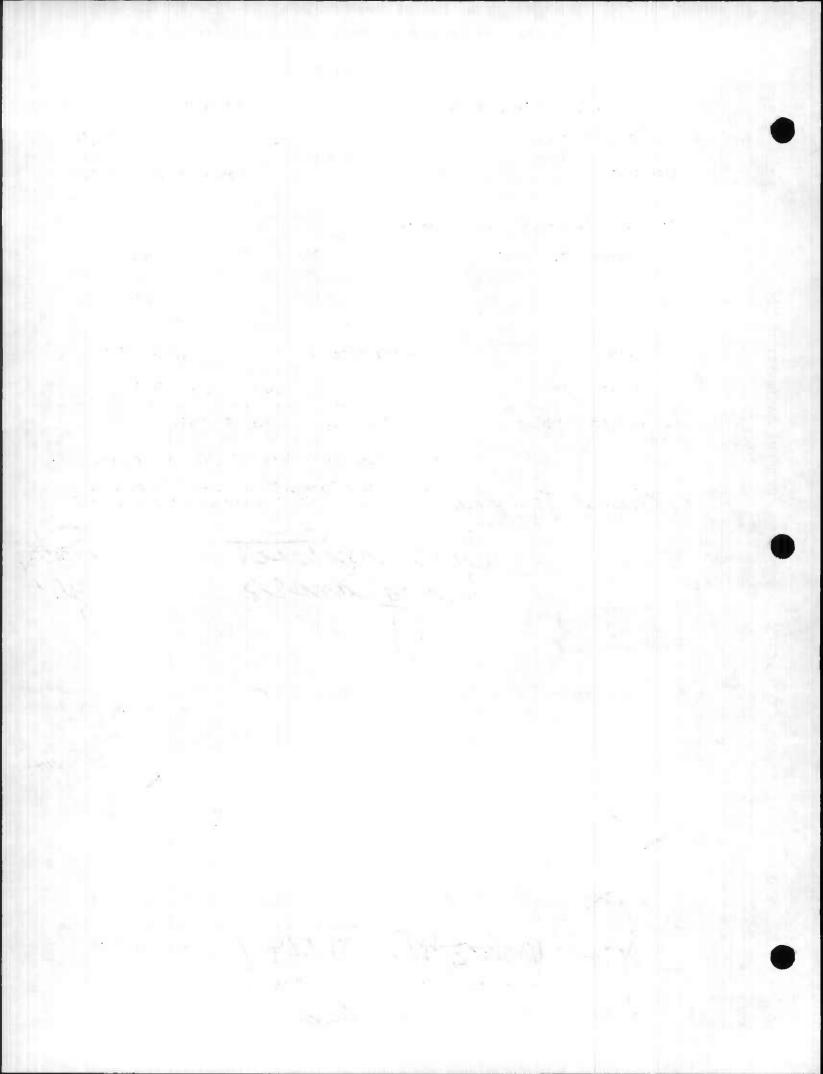
31. Date file

J.

1999

MAR 11

(Month, Day, Year)



Physician /Medical Examiner

Funeral

Director 7 is marked other than "natural", or items 23s or 28s-f show traumstic avent, the Medical Examinar must be notified at the 72 hours after I Hygiene. permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien, Important: If Itam 27 Ia marked other tha any Injury or other traumatic accounts

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

attending physician and for use as the burlal-transit be axecuted Box 68760 98 signed by the a Division of Vital Records, P.O. Deen s has director, this After thi funaral Attending

Examiner Physician/Medical à Completed Be Certification: To To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the funs edical

1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Deeth Month Day 21:40 N. March 6, GERALD DUKE 1999 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Kent & Oueen's Hospital Chestertown If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Steta or Foraign Country) Months Days 100 M 2□ F Hours 408-52-2104 61 Sept 26 1937 Tennessee **Usual Residence of Decedent** 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yas 2 No Director Davidson Nashville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 226 Lauderdale Rd. 37205 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 図 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, atc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Residential Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Surnama) Be Rebecca Young E. Duke Clyde 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nashville, TN. 37205 (wife) 226 Lauderdale Rd. Jo Anne T. Duke 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3/13/99 Woodlawn Cemetery Nashville, TN. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility M00510 Galena Funeral Home of Stephen Schaech 118 West Cross St. Galena, MD. 21635 Perf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart teilure. List only one cause on each line. Approximata Interval Between Onsat and Death Immediate Causa (Final Candiac ame diseasa or condition resulting in death) estil coma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Loronam Due to (or as e consequence of). IVYLOSIS Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23h. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown 24b. Ware autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 DNo 1 Yas 2 No 25. Was case refarred to medical axaminer? 26. Place of Deeth (Check only ona) Hospital: 1 Yas 2 No Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending investigation 1 Yas 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature as 29c. License number 29d. Dete signed (Month, Day, Year) 3/8/99 30. Name and address of person completed cause of death (Item 23a) (Type, Print)

State Registrar

Andrew Ferguson

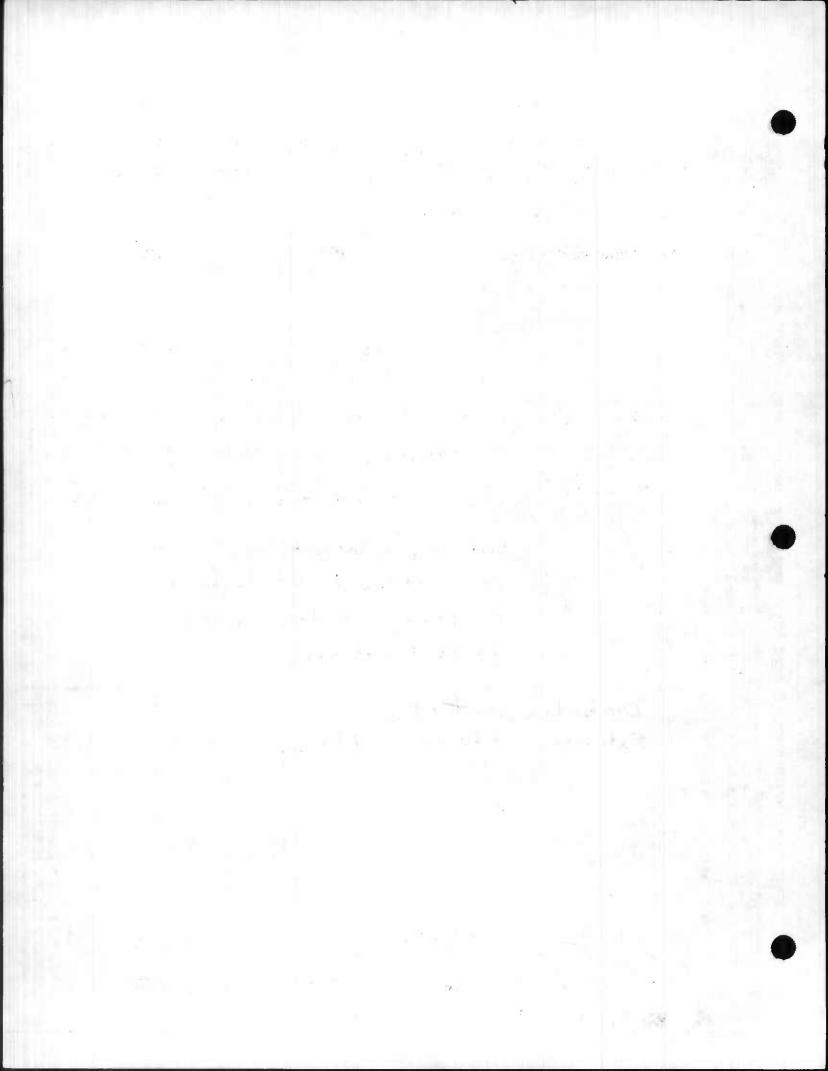
31. Data filed (Month, Day, Year)

MAR 0 8 1999

MD

32. Registrar's Signatura

120 Speer Rd. Chestertown, MD. 21620



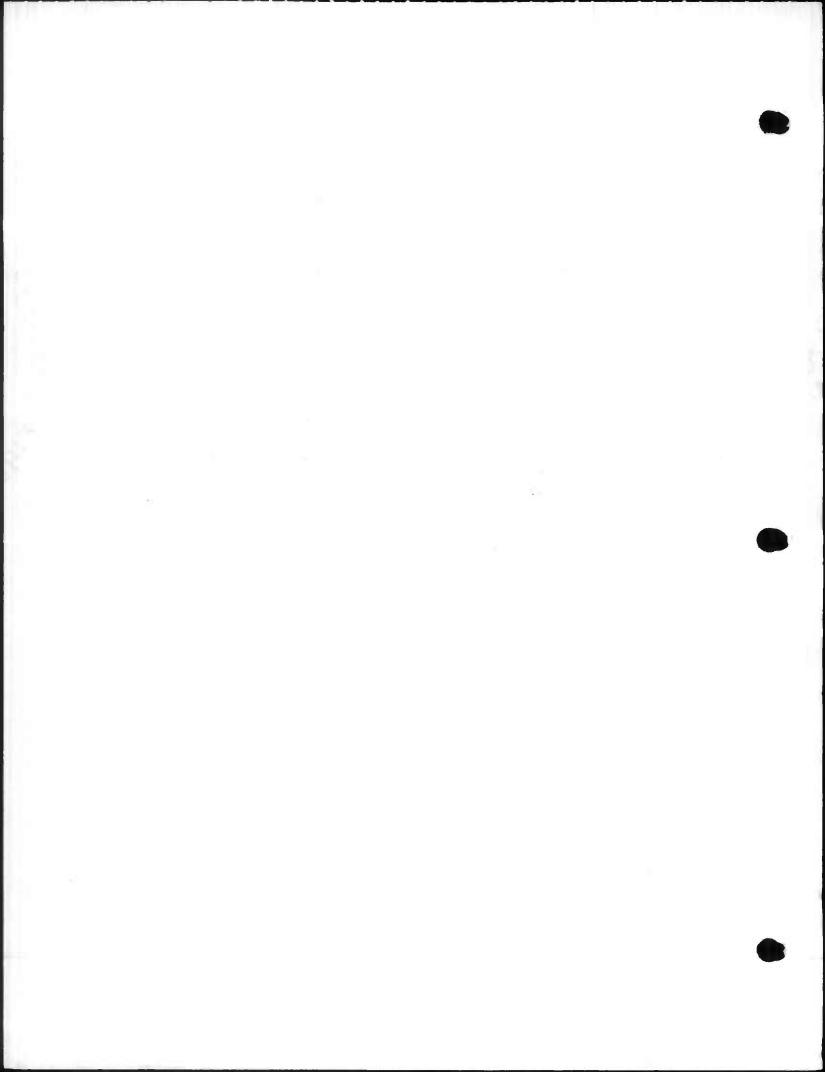
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

2

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	fler death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by t	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	loval.
INPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	al examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAN		MENT OF HEA		MENTAL HYGIE!				
	1. DECEDENT'S NAME (First, Middle, Last)	Dilical	,			2. DATE OF DEATH	ŭ ĝ	3. TIME OF DEATH		
	ESTELLE 4. SOCIAL SECURITY NUMBER	DINICOLA 5. SEX 8. AGE (In VI		UNDER 1 YEAR IF	UNDER 24 HRS.		BIRTHPLACE (State or Foreign			
	209-26-1328	1 M 2 DF 75	YRS, MC	NTHS DAYS HO		Country)				
œ	9a. FACILITY NAME (If not institution, give stre		91	CITY, TOWN OR L			9c. COUNTY			
DIRECTOR	FRESIDENCE OF DECEDENT ELKTON MD. CECIL									
REC	10a. STATE 10b. COUNTY	. ,		OWN OR LOCATION				10d. INSIDE CITY LIMITS?		
	MD. CEC	16	EL	KtON			1 TYES 2 NO			
RAL	100. STREET AND NUMBER			101. ZIP	CODE		10g. CITIZEN	OF WHAT COUNTRY?		
FUNERAL	#20 SumPter L1	9N C 12. WAS DECEDENT EVER IN U.S	ADMED	d	1921			S. A.		
BY FU	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	NO	13. WAS DECEND If yes, specify 1 YES 2	Cuban, Mexican	C ORIGIN? (Specify Ye, Puerto Rican, etc.)	14.	RACE — American Indian, Black, White, atc. Specify: WHITE		
	15. DECEDENT'S EDUCA	TION 16s	. DECEDENT'S US	UAL OCCUPATION		16b. KIND OF BU	JSINESS/INDUS			
COMPLETED	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5 +)	(Give kind of work life. Do NOT use re JELDE	done during most of tired.)	working			inment		
OM	17. FATHER'S NAME (First, Middle, Last)				MOTHER'S NAM	IE (First, Middle, Maider	n Sumame)			
BEC	John TURZ	PANSKI			ANNA	WEX	14			
9	19a. INFORMANT'S NAME (Type/Print)	,				oute Number, City or Tox	, State, Zip Co	de)		
-	ESTELLE SAU		#20	Sumpte	/LA	NE EL	Kton	MD 21921		
	20a. METHOD OF DISPOSITION 1 Description 2 Cremation 3 Remov	al from State cemeter	crematory or other	DISPOSITION (Name of place)			OCATION — City			
	4 Donation 5 Other (Specify)		BARRISO	N FOIE 22. NAME AND A			NINGS	mills mo		
	Elwal All	Moleon				,	9 7 m	vis St. Elkton		
	23. PART I. Enter the disease, or co	mplications that caused the et only one cause on each	e desth. Do not	enter the mode of	of dying, such	ss cerdlec or resp	piratory srrest	, Approximete		
	BARREDIATE OLUGE CE			-11	1			Interval Between Onset and Death		
	disease or condition resulting in desth)	Cancer	ot	The	ary	nx		34RS		
1		DUE TO (OR AS A CO	NSEOUENCE OF):					1		
CERTIFICATION	Sequentielly list conditions, b.	DUE TO (OR AS A COI	NSEQUENCE OF):							
CAT	If sny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury		- Description							
Ē	thet initieted events	DUE TO (OR AS A COI	NSEQUENCE OF):							
Ä	resulting in desth) LAST									
AL C	PART II. Other eignificent conditions	contributing to death but n	ot resulting in t	he underlying cs	use given in F			24b. WERE AUTOPSY FINDINGS		
20	Preumon		nemia			1 YES	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
MEDIC	Emphy	sema					^	OF DEATH?		
	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF D	EATH YES	Ø NO □ U	JNCERTAIN			/		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. F	PLACE OF DEATH (Check only one)						
ΙΥS	1 YES 2 NO	☐ Inpetient 2 ☐ ER/Outpetier	1 3 □ DOA 4	☐ Nursing Home 5	7					
	1 📈 Natural 5 🗌 Pending	(Month, Day, Year)	28b. TIME O	F 28c. INJURY WORK? M 1 YES		28d. DEŞCRIBE HOW	INJURY OCCUR	ED		
BY	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY — A	it home, farm, stree			28f. LOCATION (Street	and Number or I	Rural Route Number		
TED	4 Homicide determined	building, atc. (Specify)				City or Town, State)			
PLE	29a. CERTIFIER 1 CERTIFYING PHYSICI	AN: To the best of my knowledge	e, death occurred a	t the time, data and	place, and due t	o the cause(a) and me	nner sa stated.			
COMPLET		On the basis of examination and						nuse(a) and manner as stated.		
BE C	296. SIGNATURE AND TITLE OF CERTIFIER	01	In T	290	LICENSE NUME	BER	29d. DATE SI	GNED (Month, Day, Year)		
0	Harricia	Breve	MA		D228.	/3	1 2	126/99		
	30. NAME AND ADDRESS OF PERSON WHO		(ITEM 27) (Type, Pri	(L	1.1	1-1	FIL	1-		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATUR	of Control	C. L.	19/	27-6	2417	DUMR		
	MAD 0 3 1999	Genera G	1.		0					
	- FIER U 0 1333	(1)	1000	13				DHMH-16 Rev 1/89		



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of His

J /	Department	or Health and	mental	Hygiene
	Certificate	of Death		

aae	e Davis				State of Mi	arylanc		ificate of	Death	Wichtairiy	Reg. No. 9	08	733
Dhuaia			Dacedent's Nama (First, Middla, Last)								2. Data of Daath Month Day Ye		. Time of Death
	Physicia /Medic		Dilate A. Davis							March	-		9:30 A.M.
	Examine		As Espilita Norma (Mant institution aire street and symbol)					4b. City, Town, or	Location of Deat	h 4c. County			
	Funeral Director		5231 Mar 5. Social Security Nu 577-98-1	947 6. S		e (In yrs. le		If Undar 1 Yaar Months Days		Heights 8. Date of Bi (Month, Di Apr.	Prince Pr	9. Birthplace Couptry) Wash.	(Stete or Foreign
1	ww m		Usual Residence of I	Decedant 10b. County		10c. City,	Town or Loca	ition				10d.	Inside City Limits
	Mery If sh	to	Maryland	Prince G	eorge's		Ні	ilcrest	Heights				1 Yes 2 No
	r 28s	rec	10e. Street and Num					10f. Zip Code			10g. Citizen of V	Vhat Country?	
	h wit	a 0	3404 Cur	tis Driv	re #304				20746		United States		
Maryland 21215-0020 d 2 should be filed within 72 hours after death with the Meryland th and Mental Hygiene. T is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinat must be notified as	urs after deal	by Funeral Director	11. Marital Status 1 Never Marrie 3 Widowed 4		12. Was Decedent Armed Forces? 1 Yas 2 4 If Yes, Give Year or Datas:			as Decedent of I ras, specify Cub	Hispanic Origin? (ban, Mexican, Pue Spacify:	Specify Yas or Norto Rican, atc.)		e - American I ck, White, etc.	
Baltimore, Maryland 21215-0020	vithln 72 ho	Completed	(Specification (Speci	15. Decadenl's Education recity only highest grede completed) condary (0-12) College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of wo			orking 16b. Kind of Business Private			ry
7	filed with Hygiene. Ither than	ပ္ပ			1			Stude		ame (First, Middle			
and	ntal had of	Be	All and Break						Sharon		14/		
7	should Ind Men	P	19a. Informant's Nama/Relationship (Typa, Print) 19b. Malling Address (Street and Number or I								Stata Zin Co	de)	
Ma	alth and 27 is m			Cross -					Dr., #30				
re,	Health tem 27 other tr		20a. Method of Dispo		Hother	20b. Ple	aca of Disposit	tion (Neme of otory or other pla	Park	Date	20c. Location -		
E O	Peges nent of int: If its iry or o			Cremation 3 C	Removal from State			National		3/9/99	Laur	el, MD	
Baltimore, permit. Peges 1 en Department of Heali Important: If item 2 any injury or other once.	Departm Departm Importar any inju		21. Signature of Fun			111		Name and Addr			Funeral		010
			23a. Part Folar the	e disagse, or com	plications that caused one cause on each li	the death.			nning Rd.				U19 proximate
	Physician /Medical Examiner	liner	Immediata Cause (F disease or condition resulting in death)	inal	· Juni	but (Due to (or	James as a conseque	ald 7	high				
x 68760,	ificate be g physicia es the bu	Medicai Examiner	Sequentially list con- if any, leading to immoduse. Enter Under Causa (Disease or In that initiated events resulting in death) La	ditions, nadiata lying njury	c		as a conseque					1	
Вох	ettend for us	clan	0.										
P.O.	that the deed by the deteched	y Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							Yes 2□ No		e cause of deeth? ly 4 Unknown	
Records,	been s	Completed by									s an autopsy ormed?	availal	autopsy findings ble prior to letion of cause th?
	he la e he age	EO								100	Yes 2□ No	10 Y	es 2□ No
ta	Infice tifice tor, p	Be C	25. Was casa refarre	ed to medical					26. Placa of De	eath (Check only	one)	1	
>	ysici is cer direc	ToB	examiner? 1% Yes 2□ N	lo	Hospital:	ent 2DE	R/Outpatient	3 DOA O	her: 4 Nursing	Home 5 □ Res	idanca 6 🗆 Oth	er (Specify) a	at scene
0	g Ph	:u	27. Mannar of Daath	5 □ Bonding	28a. Data of Inju	ry v Year)	28b. Time of Injury	28c. Inju	iry at	28d. Describe	how injury occur	red	
0	ath. vr: Afr	atic	1 ☐ Natural 2 ☐ Accident	5 Pending investigation	Found 3/2	453	94 Aug		Yes 2 No	Subje	It flo		
Division of Vital	r Atter de iracto	Certification:	3 ☐ Suicide 4 Homicida	6 Could not be datermined		ury - At hor c. (Specify)	ne, farm, stree	et, factory, office			(Straat end Numb	4	oute Number,
	thal o						51	mit		Pake To	ingle the	S Me	my (and
	To the Hospital or Attanding Physician: The law within 24 hours efter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only 2 one)	I□ Certifying Ph ☑ Medical Exam	ysician: To the best niner: On the basis of and manner st	f examination	riedga, death o on and/or inve	occurred at the t stigation, in my	ima, data and plac opinion, death occ	ce, and due to the curred at the tima	data and place,	and due to the	d. / e cause(s)
	within To th comp	ž	29b. Signature and t	tie of certifier	111			29c. Licen	se number		29d. Date signe	d (Month, Day	r, Year)
			17/4	colone l	1 Fine	~		0	C.M.E.	-	March 0	3. 1999	9
1	2		-71		completed cause of a	leath (Item		rint)					
1			31. Date filed (Month	PE Mit		ar's Signati		Penn St	reet, Ba	altimore	Maryla	nd 2120)1
	Stat Registra	-	MAR	0 5 1999	2. Hegisti	ar o oignati	3. 4	bout	,				

DHMH 16 Rev 6/95

Mark on he h

99-1232-033 jhm RUSSELL J DUNN

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene (

1				Certifica	ate of Death	Re	g. No.		
	Physician /Medical	Decedent's Name (First, Middle, L. RUSSELL JUNI)			MIE.	2. Date of Death MARCH O	3, Dey 1999 Yeer	3. Time of Death 22:55 PM	
	Examiner	4a Facility Name (# not institution, gi SOUTHERN MARYLAN			4b. City, Town, Clinton		4c. County of Deeth PRINCE G		
	Funeral Director	5. Sociel Security Number 241-64-5900 6.	rs. 8. Date of Birth (Month, Dey, February	8. Date of Birth 9. Birthplece (State or F. Country) February 20, 1941 North Carolin					
21215-0020 d with 72 hours effer deeth with the Meryland jeine. r than "natural", or items 23s or 28s-f show the Merical Examiner must be notified at	Maryland H show fied at	Usual Residence of Decedent 10a. State 10b. County Maryland Prince		City, Town or Location				10d. Inside City Limits 1 🖄 Yes 2 □ No	
	iter deeth with the Mei r items 23s or 28s-1 s oner must be notified funeral Director	10e. Street and Number 11304 Mary Cath	erine Drive		Zip Code 20735	10	10g. Citizen of What Country? U.S.A.		
	urs efter al', or its ramine by Fui	3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:		cedent of Hispanic Origin? pecify Cuban, Mexican, Pu 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Amer Bleck, White Specify: B1 a	e, etc.	
	n 72	15. Decedent's E(Specify only highest gi	ducation ade completed) College (1-4or 5+) 2 years	16e. Decedent's U (Give kind of life. DO NOT Mechan	work done during most of v Tuse retired)	vorking	Private	ndustry	
Maryland	d out He	17. Father's Neme (First, Middle, Las	•		18. Mother's Naomi	leme (First, Middle, M Dunn	feiden Sumeme)		
	ges 1 and 2 should t of Health and Mer if item 27 is marke or other traumatic	19e. Informent's Neme/Reletionship Frieda C. Dunn/i	Vife		ess (Street end Number or lvia Drive,				
Baltimore,	0 E # >	20e. Method of Disposition 1 Buriel 2 Cremetion 3 4 Donation 5 Other (Special Content of the Co	Middlesex,						
Ball	pemil. Page Department of Important: if any injury or once.	21. Signeture of Funerel Service Lice	. Percentie	J. B. 7474	end Address of Facility JENKINS FUNE Landover Roa	d, Landove	er, Maryla		
	Physician /Medical Examiner	23e. Part1. Enter the dise e, or conshock, or heart for List only Immediate Ceuse (Finet disease or condition resulting in death)	· ATHORNOSCI	4	an ior is au		4	Approximete Interval Between Onset and Deeth	
68760,	certificate be executed rating physician and use as the burial-trensit rating the control of the	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Lest	С.	(or es a consequence o	1 2 4				
O. Box	ndin use		dcontributing to death but not re	esulting in the underlyin	g cause given in Pert I.	23b. Dld to	bacco use contribute	1 /	
0	requires that the death een signed by the ette hould be deteched for sted by Physicia					1 T Ye		Nere eutopsy findings	
Records,	has b					perform	ned?	ovellable prior to completion of cause of deeth?	
Vital	clan: entific ector,	25. Wes case referred to medical examiner?	Ussalad			Deeth (Check only on	θ)		
of	Pis Pis	1X Yes 2 No 27. Manner of Deeth		1		Home 5 Reside	nca 6 Other (Spec	cify)	
Division	or the	1 Neturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not 1	90	28b. Time of Injury M	28c. Injury et Work? 1 Yes 2 No			mal Davida Atrondo	
Divi	tal or Attend at Director: / ed in by the f	4 Homicide determined		nome, farm, street, fac cify)	tory, office	28f. Location (St. City or Town	reet and Number or Ru n, Stete)	rei Houte Number,	
	Hospital or 24 hours efte Funeral Dir. Metely filled in edical Cert		nyelclan: To the best of my ki miner: On the basis of exami- end menner steted.						

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) wayersi

111 Penn Street, Baltimore, Maryland 21201

29c. License number

OCME

29d. Dete signed (Month, Dey, Year)

MARCH 04, 1999

HD QUANTO D

31. Dete filed (Month, Dey, Year)

MAR 0 5 1999 State Registrar

32 Registrer's Signeture



ميد زي ا

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death March **Physician** WALTER DOBY, JR. 9:54 PM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sax 1 → M 2 → F 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 10,1943 Months 259-66-3663 55 November Georgia Director Usual Rasidance of Dacedent 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23a or 28a-f show the Wedical Examiner must be notified at Maryland Prince George's 100 Yas 2 □ No Director Upper Marlboro 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 20772 4303 Fairway View Terrace U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: 11 Marital Status Was Dacedant of Hispanic Origin? (Specify Yas or Notif Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. Black, White, atc. filed within 72 hours after 1 Navar Married 2 Married Specify: Black Baitimore, Maryland 21215-0020 1 Yas 2 No Specify: À 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within 7. Department of Heelth and Mentel Hygiene. Important: if item 27 is marked other than "na any Injury or other treumatic event, fine Wedl. 2016. Elementary/Secondary (0-12) Collega (1-4or 5+) Overhead Linesman Private 12th 17. Fathar's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) Be Walter Doby, Sr. Carrie Dunbar 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 20772 4303 Fairway View Terrace, Upper Marlboro, MD Kenneth B. Doby/Son 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 03/13 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Olive Memorial Gdns Augusta, Gerogia 4 ☐ Donation 5 ☐ Othar (Specify) 1999 21. Signature of Funaral Sarvice Licensee J. B. Jenkins Funeral Home Na ercen 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Entar tha disaase, or complications that caused tha death. Do not antar tha mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death **Physician** /Medical Immediata Causa (Finat disaasa or condition rasulting in daath) hEMIC Examiner Examine physician and the burial-transit that the death certificate be axecuted Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disaese or Injury that initiated evants resulting in death) Last Dua to (of as a consequent P.O. Box 68760. rongno Physician/Medical Dua to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No

þ Completed page 2 s Be

2

à signed b The law requires or Attanding Physician: this After after death. à hours

Division of Vital Records. Certification: 24 hours • Funeral Medical Within 2 To the 8 # 0

State Registrar

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. (Check only one) 29b. Signature 478 Full Ex STEVEN 31. Data filed (Month, Day, Year)

5 Pending invastigation

6 ☐ Could not be datarmined

25. Was casa rafarred to medical axaminar?

1 Yas 2 Tho

27. Menner of Beath

1 Natural

2 Accident

3 ☐ Suicide

29a. Cartifian

4 - Homicide

0

1 Depatiant 2 ER/Outpatient 3 DOA

28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28b. Time of

29c. Licansa number

1 Yes 2 No

29d. Data signed (Month, Day, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

24a. Was an autopsy performed?

Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify)

26. Place of Deeth (Check only one)

1 Yas 2 UNI

28d. Describe how triury occurred

24b. Wara autopsy findings available prior to complation of cause of death?

1 □ Yas 2 □ No

30. Name and address of person who complated causa of death (Itam 23a) (Type, Print)

28a. Date of injury (Month, Day Year)

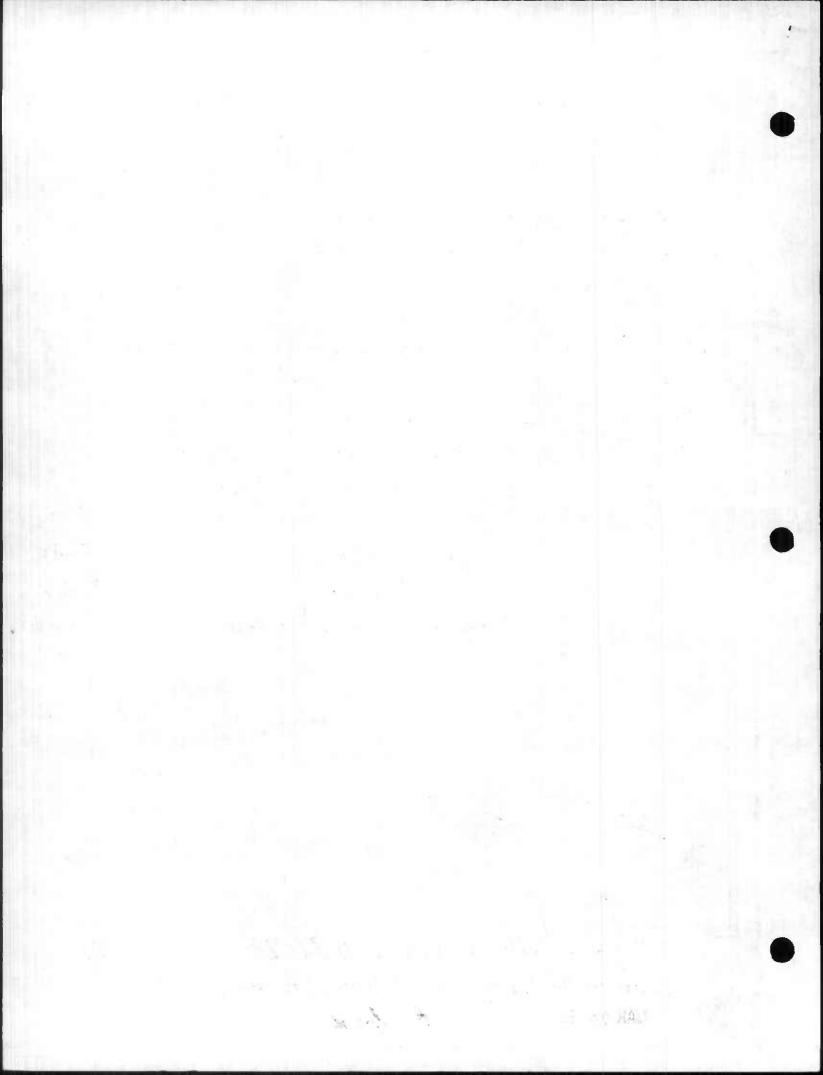
Acoma Hank 00 (Annol

(Decrifying Physician: To tha best of my knowledge, deeth occurred et tha time, date and place, and dua to the ceusa(s) and mannar as stated.

28c. Injury at Work?

32. Registrar's Signatura MAR 0 5 1999

Hospital:



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Death 3. Time of Deeth L30 **Physician** DAZ William MARCH /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner HOSPITAL RANDAUS TONN BALTI MORE Conton MONTHWEST If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foraign Country) 6 Say **Funeral** 1 M 2 F 225-34-9328 Director 69 SEPT. 15,1929 VIRGINIA Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flams 23a or 28a-f show traumatic event, its Medical Examiner must be notified at 1 Ves 2 □ No Directo N/AMARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1810 COLMAR ROAD 21207 Funerai U.S.A. death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxicen, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiena. If them 27 is marked other than "natural", or fiell important: If them 27 is marked other than "natural", or fiell 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: AFRO AMERICAN by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest g Elemantary/Secondary (0-12) College (1-4or 5+) 8 TRUCK DRIVER FRETGHT 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) GAM DAY N/A19b. Mailing Addrass (Straet end Number or Rurel Route Number, City or Town, Stata, Zip Coda) 19a. Informent's Name/Relationship (Type, Print) PHILLIP BALL 1810 COLMAR ROAD BALTIMORE, MD 21207 Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Locetion - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Crametion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or FIRST BAPTIST CHURCH 3/9/99 HEATHSVILLE, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility BERRY O. WADDY POBOX 305 6784 MARY BALL RD LANCASTER, VA 22503 23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or haart fallura. List only one causa on each lina. Approximate Interval Batwean Onset and Death **Physician** FEW DAYS /Medical Immediate Ceuse (Finel REUMONTA diseasa or condition resulting in death) Examiner Due to (or as e consequence of) Examiner ician and burial-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Disaase or injury that inflated events resulting in deeth) Last Due to (or es e consequence of): certificate be axe physician Box 68760 Physician/Medicai the Due to (or es e consequence of) 88 980 Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Wiknown END STAGE RENAL DISEASE; OLD CENERALD. by sign d b 24b. Were autopsy findings avellable prior to completion of ceuse of daath? VASCULAR ACCIDENT, CORONARY ANTONY Completed 24a. Was en autopsy performed? DISTASE 2000 1 Tyes 1 Yas 2 ANS Division of Vital 25. Wes cese rafarrad to-medical Be 26. Place of Daeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Department 2 ER/Outpatient 3 DOA 1 Yes 2 No 10 funeral 27. Manne of Death 28a. Data of Injury (Month, Day Yaar) Certification: 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 1 Natural 5 Pending Investigation after death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datermined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 D Homicide 6 Hospital 24 hours a 24 hours a 29e. Certifier (Check only one) 🗹 Certifying Physician: To tha best of my knowledga, death occurred et tha time, date and plece, end due to the ceuse(s) end menner as steted. Medicai 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at tha tima, data end place, and due to the cause(s) end manner stated. To the To the To the F 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of partillion 19502 MAICH 3, 1999 MONTHWIST HOSPITAL CONTRE 30. Name end address of person who complated cause of death (Itam 23a) (Type, Print)

MD

CONARA

32. Registrar's Signature

Registrar

GRLANDO

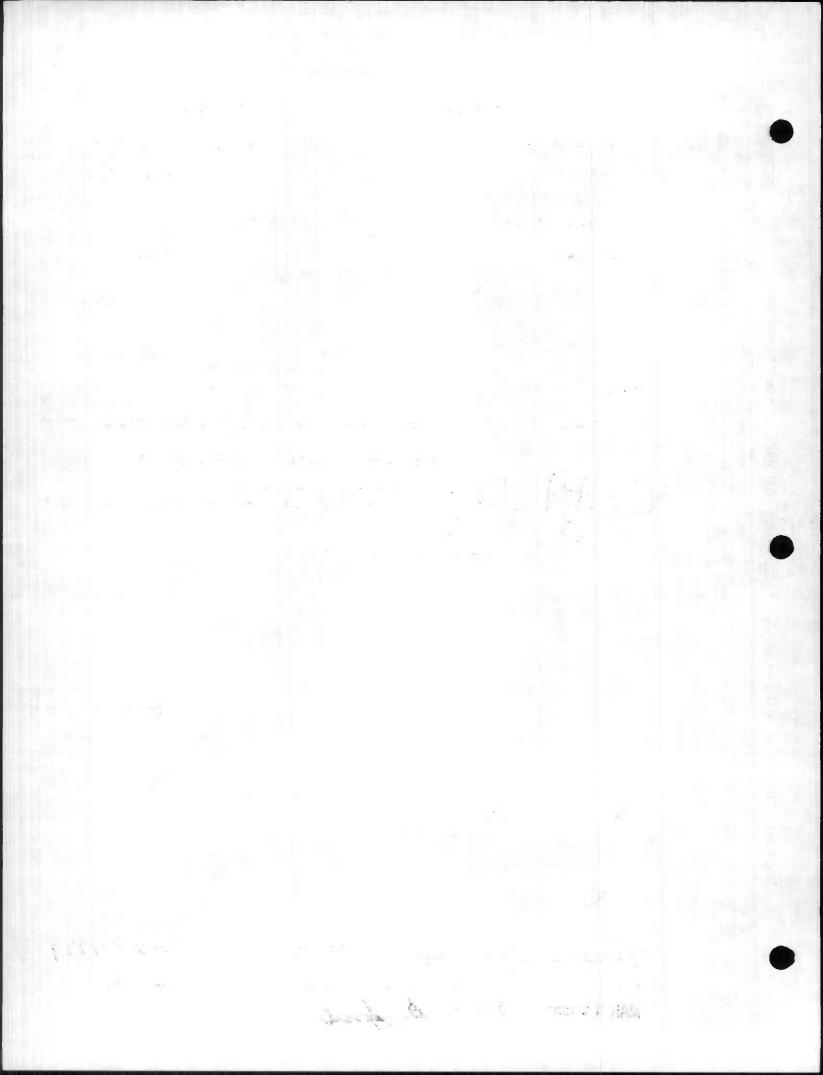
31. Date filed (Month, Day, Year)

MAR 0 5 1999

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1. Decedent's Neme (First, Middle, Last)								2. Dete		, No.		3. Time of Deeth	
ysician		Nettie		Die	ckens					Febr		28, 1	Yeer 999 1	1:02 am	
Medical kaminer	4 -	Fecility Neme (If not in	stitution, give					4	b. City, Town, or		-	4c. County		TTOE GM	
Nammer .										Monte	Montgomery				
neral	5.	Sociel Security Number	6. Se	ex 7. Age (In yrs. last birthday) if Under 1			if Under 1	Yeer	if Under 24 Hrs Hours Min	8. Dete				e (Stete or Foreign	
ector	579-30-6249 1 M 201F 89 Yrs. Months Deys Hours Mir						Jan.	16,	1910	Virg	inia				
notthed at	10		County		10c. Ci	ty, Town or Loca	ation	-		10d. inside City Limits 1\(\bar{\Delta}\) Yes 2 □ No					
Director	M	aryland Pr	ince (George's West					Hyattsv	ille					
Sire oil	10	0e. Streef end Number		10f. Zip Code							100	g. Citizen of V		?	
a la		6004 36th A	Avenue					2078	82			U.S.A	•		
deal Economic rount eted by Funeral		Maritel Status Never Merried 2 Widowed 4 □ Di		12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates:					ispenic Origin? (in, Mexican, Pue Specity:	Specify Yes rto Rican, etc	or No- c.)		e - American ck, White, etc. Whi		
2		15. De	ecedent's Ed	ucetion		16e. Decede	ent's Usuel (Occup	etion		16	6b. Kind of Bu	usiness/Indus	itry	
Set		(Specify only	highest gree	de completed) (Give kind of life, DO NO)			ind of work O NOT use	done d	during most of wo	orking					
Completed		Elementary/Secondary ((0-12)	College (1-	40r 5+)		omemal					Own	Home		
T O	17	7. Fether's Name (First, I	Viiddle, Last)						18. Mother's Ne	me (First, M	iddle, Ma				
To Bo		Hammond		Kirby					Annie		Pear				
	-	9a. Informent's Name/Re				10h Malling	Address /	Street	end Number or F				State Zin Co	vde)	
		Terry H. Gilead - Friend 7100 Claymore Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place)								Hyattsville, Maryland 20782					
6	120	1 N Buriel 2 □ Cren		Removel from S	tate	cemetery, creme	etory or other	er plec	*	Dete 20c. Location - City or Town, Stet					
5		4 □ Donetion 5 □ O	ther (Specify)	Geo	orge Wash				03/03/99 Adelphi, Maryland					
Suce	5	21. Signature of Funeral Survice Ucunsee 22. Name end Address of Fecility Gasch's Funeral Home, P.A.													
		1	Va. I	COM IN	100 10	47	39 Ba	1+1	more Av	enue	Hyat	tevill1	e MD	20781	
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Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No." 1. Decedent's Name (First, Middle, Lest) 2. Data of Daath 3. Time of Death PEBRUARY Day 1711 Am 24,1999 Cheatham Cleve Davis, 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death LANDOVEK 3531 EDWARD STREET PRINCE GEORGES If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) Months 1 M 2 □ F Yrs. 231-38-5685 62 Virginia Feb. Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Landover 1 No 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3531 Edward St. 20785 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, Whita, atc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Black Specify: 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Computer analyst Government 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) Cheatham Cleve Davis, Sr. Rosa Luvenia Lewis 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) Karen Cheek-Deajon 12426 Versailles Drive, Houston, Texas 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 3/1/99 Clinton, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licanes Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final SEIZURE DISORDER disease or condition rasulting In death) Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of):

/Medical Examiner

8

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Funeral

Director

I merked other than "natural", or Items 23s or 25s-1 show traumatic event, the Medical Examinar must be notified at

semit. Pages 1 and 2 should be filed within 72 hours efter of population of Health and Mental Hygiene. Insportant: if item 27 is marked other than "natural", or item

and Mental I

Maryland 21215-0020

Baltimore,

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death

Physician buriel-tren and

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Director: After

To the Hospital or within 24 hours at Tp the Funeral D

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P.O.

Division of Vital

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Examiner Physician/Medicai þ Completed Be 2 27. Manner of Death Certification:

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC ETHANOL ABUSE

CHRONIC SMOKING

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy

24b. Were eutopsy findings available prior to completion of ceuse of death?

2 No 26. Piece of Deeth (Check only one)

1 ☐ Yas 2 ☐ No

25. Wes cese referred to medical examiner? examiner:

Hospital: 5 Pending investigation

6 Could not be determined

28e. Dete of Injury (Month, Dev Yeer)

1 inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

DRIVE, CHEVERY, MARSYLAND 20785

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier

1 Netural

2 Accident 3 Sulcide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end plece, and due to the ceuse(s) and manner stated. 29d. Date signed (Month, Dey, Year)

29b. Signature a

29c. Licansa number

30. Neme and eddress of person who completed ceutin of court (Item 234) (Type, Print)

MARID GOLLE

M 3001 HOSPITAL JR 32 Registrar's Signature

State Registrar

Medicai

MAR R 1 1999 Jan Band

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1. Decedant's Nama (First, Middla, Li	est)				2. Data of De	Reg. No.	3. Time of Death			
an :al	JAMES TAYLOR	DODSON				FEBRUAI					
r	4e Facility Name (If not institution, gir	ve street and number)		4b. City, Town, or L	ocation of Deeth	4c. County of I				
Ш	7732 Garrison	Road			Hyatts	7ille	Prince C	Georges			
at 💮		Sex 7. A	ga (In yrs. last birthday	Months Days	if Under 24 Hrs. Hours Min.	8. Data of Bird (Month, Da	th y, Year) 9.	Birthplaca (Stata or Foraign Country)			
	237-14-9214	16 W 201	81 Yrs.			July 6,	1917 No	orth Carolina			
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0	Maryland Prince	Coorgos	Hyatts	wille				1 ☐ Yas 2 ☒ No			
Director	10e. Street and Number	Georges	liyaces	10f. Zip Coda			10g. Citizan of Wha	t Country?			
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Completed by Fur	11. Marital Status	12. Was Decedan	t Ever in U,S. 13.		Hispanic Origin? (Sp an, Mexican, Puarto	ecify Yes or No		Amarican Indian,			
	1 Naver Married 2 Married 3 Widowad 4 Divorcad	Armed Forcas 1 ☑ Yas 2 ☐ If Yas, Giva Yaar or Datas:		If Yas, specify Cub 1 ☐ Yas 2 ᡮ No		Rican, atc.)	Specify:	White, atc. White			
	15. Decedent's E	ducation	16a, Dece	edant's Usual Occup	pation	ina	16b. Kind of Busin				
	(Specify only highast gr Elamantary/Secondary (0-12)	Collega (1-4or	5+)	DO NOT usa ratire	during most of work d)	n g					
	12	2		Engineer			Self-Empl	oyed			
	17. Fathar's Nama (First, Middla, Las	1)			18. Mothar's Nam	e (First, Middla,	Maidan Sumama)				
	Walter W. Dodso	n				ce Tayl					
	19a. Informant's Name/Ralationship	(Type, Print)	19b. Mai	ling Address (Street	t and Numbar or Rui	ral Route Numbe	er, City or Town, Sta	ta, Zip Coda)			
	Virginia T. Do	dson-Wife						Land 20784			
	20a. Mathod of Disposition 1₺ Burial 2☐ Cramation 3 [Ramoval from State	20b. Place of Disp camatary, cra	osition (Nama of amatory or othar ple	ca)	Data	20c. Location - City	y or Town, Stete			
	4 □ Donation 5 □ Othar (Special			coln Ceme	etery !	2-26-99	Brentwood	d, Maryland			
	21. Signature of Funeral Service Lice	ngee O		22. Nema and Addra	ass of Facility	- 1 II am a					
	* due X	Johns	ON 3	401 Blade	nsburg Rd	l., Bren	twood, Ma	ryland 20722			
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ysi	Part II. Other significant conditions	contributing to death	but not rasulting in tha	undarlying causa gi	van in Part I.			Dute to the cause of death? Probably 4 Unknown			
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pleted b	Non insulin De	pendont?	Diabetes M	elilus; Ca	rdiac Faile	24e. Was perio	an eutopsy 2 rmad?	4b. Wera autopsy findings available prior to completion of cause of death?			
E	Chronic Renal 2	arluno: 0	bstructive	Urobath	14	10	Yas 2 No	1 ☐ Yas 2 ☐ No			
Sec	25. Was casa rafarred to madical	- 37(11/6 / 0		Ciropun	26. Placa of Daa	th (Check only o	ona)				
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	27. Menner of Deeth 1 Naturel 5 □ Panding	28a. Date of Inj (Month, D	ury ay Year) 28b. Tima Injury	of 28c. fnju	ry at	28d. Dascribe	how Injury occurred				
atic	2 ☐ Accidant invastigation	on			Yes 2□No						
Certific	3 Suicida 6 Could not to datarmined	28a. Placa of Ir	njury - At homa, farm, s itc. <i>(Specify)</i>	traat, factory, offica		28f. Location (. City or Tol		or Rural Route Number,			
edicai			t of my knowladge, dea of axamination and/or li tated.								
ledic	29b. Signature and titla of certifiar	01	44 6	29c. Licens	se number	10	29d. Data signed (A	Aonth, Day, Year)			
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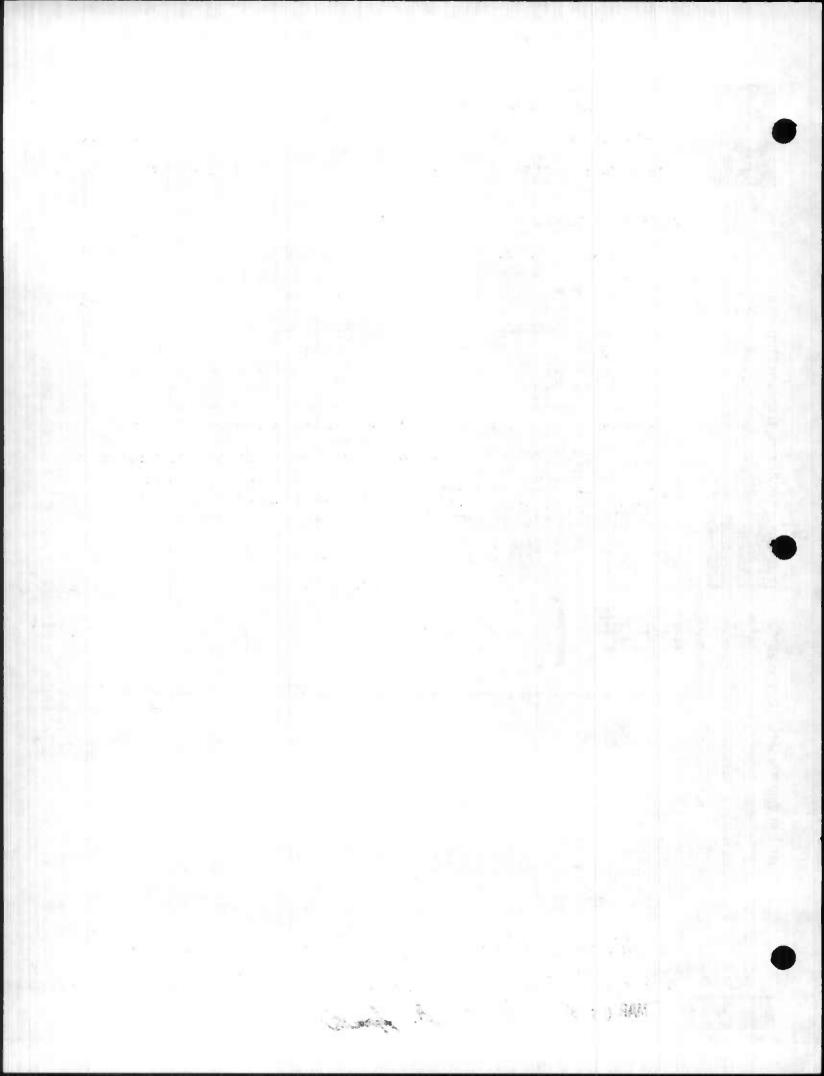
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Month Joseph Dorsey 10:30PM /Medical 4b. City, Town, or Location of Deeth 4a Facility Nama (If not institution, give street and number) 4c. County of Deeth Examiner Silver Spring Medlantic Manor at Lavhill Montgomery If Under 1 Yaar 5 Social Security Number 8. Data of Birth (Month, Day Year) Oct. 15, 1912 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foraign **Funeral** Days 1 ₹M 2 □ F Months Hours Wash., D.C. 578-48-8423 86 Yrs. Director Usuel Rasidance of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits the Mande 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 √Yas 2 No Director District of Columbia Washington 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 1328 Staples St., N.E. 20002 United States death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14 Rece - American Indian 11. Merital Stetus Black, Whita, atc. 1 □ Never Married 2 □ Merried 1 ☐ Yas 2 ☐ No If Yas, Giva X Yaar or Datas: Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: þ Black. 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grada complated) 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Hygiena. Elementery/Secondery (0-12) College (1-4or 5+) Printer Government 18. Mother's Nema (First, Middle, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Pages 1 end 2 should be filt ment of Health and Mental Hyant: If item 27 is marked other ury or other traumatic eventury or other traumatic eventuals. Milton Dorsey Janie Bailey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a, Informant's Nama/Ralationship (Type, Print) 3713 - 26th St., N.E. Wash., Portia T. Craig - Daughter D.C. 20018 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematery, crematory or other place) Date 20c. Location - City or Town, Stata 1K Burial 2 Cramation 3 Ramoval from Stata permit. Page Department of Important: If any Injury or 3/6/99 Mt. Olivet Cemetery Washington, D.C. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Sarvice Licans 22. Name and Addrass of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shick, or heart failure. List only one ceuse on each line. Approximata Intervel Between Onsat and Death Physician Immediata Causa (Final disaasa or condition rasulting in daath) /Medical Examiner Examiner physician and the buriel-transit Sequentielly list conditions, if any, laading to immediata ceusa. Entar Underlying Causa (Disaasa or Injury that initiated avants rasulting in death) Last Due to (or es e consequence of): the deeth certificate be exe Division of Vital Records, P.O. Box 68760, men 49 Physician/Medical Due to (or as e consequance of) 80 esn 0 Part If. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? ed by the detached 1 Yes 2 No 3 Probably 4 Unknown signed I à 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? Completed complation of ceuse of death? has 2/2 No 1 ☐ Yas 2 ☐ No certificate or Attending Physician: ofter death. Director: After this certifica funeral director. 25. Was cese referred to medical examiner? Be 26. Placa of Death (Check only one) 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) OL 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28e. Dete of fnjury -(Month, Dey Yaar) 28d. Dascribe how Injury occurred 28b. Tima of 28c. fnjury at Work? Certification: 1 Naturel 5 Panding invastigation 1 Yas 2 No 2 Accidant 3 Suicide 6 Could not be detarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 3 4 | Homicide 24 hours Funeral Hospital 1 Certifying Physicfan: To the bast of my knowledge, death occurred et the time, deta and plece, and due to the cause(s) and manner as steted.

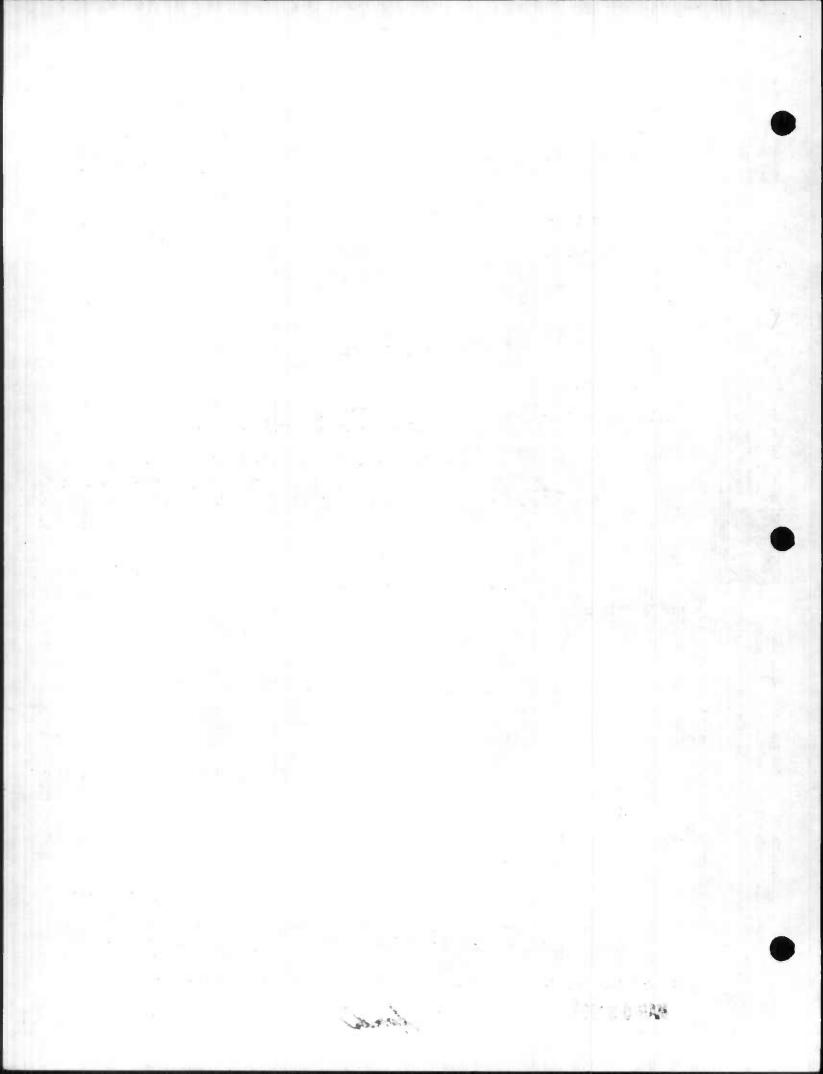
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, deta and place, and due to the cause(s) and manner stated. edical 29a. Cartifiar To the To the To the I 29d. Date signed (Month, Dey, Year) 29b. Signatura and title of certifier 29c. License number who completed causa of death (Itam 23a) (Type, Print) 0 12016 ne 2. Registrar's Signature Registrar



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State of Maryland / Department of Health and Mental Hygiene

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	neral ector	5. Social Security Number 6. 047–07–8750 Usual Rasidanca of Decedant	1 M 2 □ F 7. A	ga (In yrs. last bi		Under 1 Yaer onths Days	If Undar 24 H Hours M		ay, Year) 15, 1916	9. Birthpla Countr Winnp	ca (Stata or Foreign y) Deg, Canada			
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9 9	be notified	10e. Street and Number				10f. Zip Coda			10g. Citizen of	What Countr	у?			
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- 6	after death with the Maryla or thems 23e or 28e-f sho iminer must be notified at / Funeral Director	11. Marital Stetus	12. Was Decedent Armed Forcas	12. Was Decedent Evar in U,S. 13.			dispante Origin?	(Specify Yes or Narto Rican, atc.)	o- 14. Rac	e - Amarica ck, Whita, et				
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UNISIO To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A	pletely fi	(Check only one)	hysician: To the best iminer: On the basis of and mannar st	f axaminetion ar	nd/or invasti	igation, in my	opinion, death oc	curred at the time	, dete and placa,	end due to t	ted. the ceuse(s)			
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(6	2)	30. Nama end address of person who Bernard Stopak,					#840. CI	nevv Chas	se. MD	20815				
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Re	gistrar	MAR 0 2 1999	La nes as	13.	los	Ki								



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** CLEMENT CULBERT DICKENS 26, 1999 8:32AM **FEBRUARY** /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner CLINTON Prince George's SOUTHERN MARYLAND HOSPITAL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country ASH., DC 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days Hours 1₩ 2□ F 68 Yrs. 578-34-4661 **Director** March 6, 1930 Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Marylan Department of Haalth and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any hjury or other traumatic event, the Macical Examples must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Prince George'S Ft. Washington Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20744 512 Bentwood DRIVE Funeral 12. Was Decedent Ever in U.S.
Armed Forcas?

1 GPyes 2 No
If Yes, Give 1950-1990

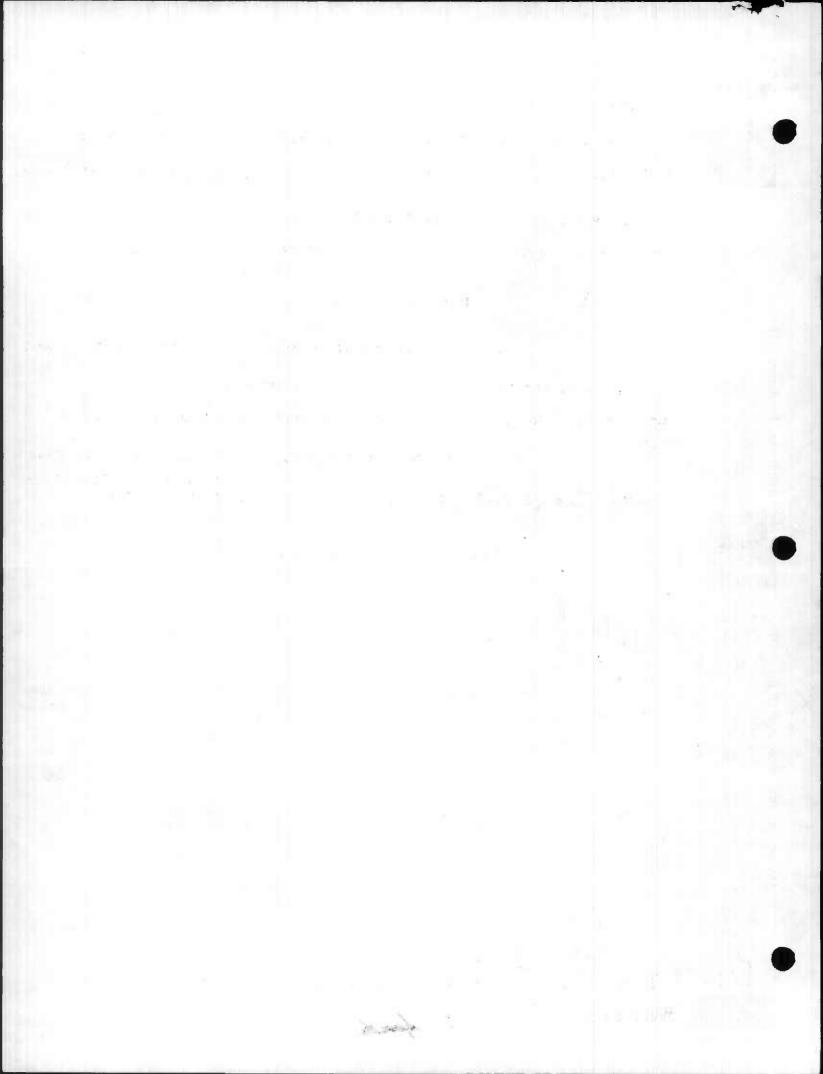
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) GOVT .- DEPT. OF NAVY GRAPHIC ILLUSTRATOR 3 YRS. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be SARAH ROSS NATHANIEL A. DICKENS 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 512 BENTWOOD DRIVE FT. WASHINGTON, MD ONEY F. DICKENS/ SPOUSE 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 3-9-99 ARLINGTON NATIONAL CEM. ARLINGTON , VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility MARSHALL'S FUNERAL HOME OF MD 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. 4308 SUITLAND RD. SUITLAND, MD Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CHRONIC DISEASE OBSTRUCTIVE LUNG Examiner Due to (or as a consequence of) Examiner the ettending physician and hed for use as the burial-transit certificata be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Dua to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. P.0 23b. Did tobacco use contribute to the cause of deeth? 1 Yee 2 No 3 Probably 4 Unknown signed by IN EUMO THORAX Division of Vital Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed cartificate hes 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2No 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 Tyes 2 No Investigation or Attend efter death Director: 2 Accident 28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stele) 3 Suicide 5 4 T Homicide To the Hospital
Whin 24 hours of
To the Funeral Complately filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only 29b. Signature and title of the 29c. Licensa number 29d. Date signed, (Month, Dev. Year) 9 0053885 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 7501 SURPATTS ROAD #307 CLINTON 20735 KAMANAN VENKAT-S. 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature

DHMH 16 Rev 6/95

Registrar

MAR 0 2 1999



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

						Cei	tificate	e of	Death			Reg. No.	99	08/4	3	
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	8703 Cranb			7 4-0	fla la d	na da Cadda ada	If Under	1 Vear		hesd		th		tgomery		
tor	5. Social Security Number 215–18–0229 Usual Residence of Dece		59X 1 □ M 2 🛣 F	7. Age 7.	(in yrs. ies	Yrs.	Months	Days	Hours	Min.	8. Dete of Bir (Month, De Oct. 30	y, Year)	0	rthplace (Stete Country) ryland	or Fore	
-		County			10c. City,	Town or Lo	cation							10d. inside	City Limi	
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al Director	10e. Street and Number 8703 Cranbr	ook C	ourt				10f. Zip					10g. Citlz	en of What C	Country?		
by Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4 D		12. Was Dec Armed F 1 Yes If Yes, G Year or I	orces? 2 X No ive		-	Was Decede f Yes, speci 1 ☐ Yes 2	ify Cub	an, Mexican	gin? (Sp , Puerto	ecify Yes or No Rican, etc.)		4. Race - Am Black, Wh Specify:	nericen Indian, lite, etc.		
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	17. Father's Name (First,	12	1		1	Homemaker 18. Mother's Name (First, Mi					a (First Middle		n Home	3		
	Jesse Lee D								Lulu Frances							
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-	20e. Method of Disposition 1 1 Burial 2 ☐ Crer	n			20b. Plac	ce of Disponetery, crer	sition (Nem	e of her pla	ce)	1	Date			r Town, State		
	4 Donetion 5 C		_		Gate				emeter		3/2/99			ring, M		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** 1999 MARCH 1, 4:20 AM MABEL ELIZABETH DUCKETT /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL PRINCE GEORGE CT.TN/TON If Undar 1 Year If Undar 24 Hrs. Birthplace (Stata or Foraign Country) 5 Social Security Number 7. Aga (In yrs. last birthday) 6 Sax **Funeral** Months Deys Hours Min 1□M 21 F Yrs 7, 1926 MARYLAND 72 AUG. **Director** 213-22-1844 Usual Rasidence of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show show 1 Yas 2 □ No Director MARYLAND PRINCE GEORGE CLINTON 10e. Street and Number 9106 PINEVIEW LANE 10f. Zip Coda 10g. Citizen of What Country? "natural", or flems 23s or edical Examiner must be UNITED STATES FUTURE CARE NURSING HOME 20735 Funeral 12. Was Decedent Ever In U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Detes: 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. permit. Pages 1 and 2 should be filled within 72 hours after of Department of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", or flet any Injury or other traumatic event, the Mexical Examine page. 1☑ Never Marriad 2☐ Married 1 Yas 2 No Spacify Specify: g BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 18e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15 Decadent's Education (Specify only highest grada completed) Elementary/Secondary (0-12) Collega (1-4or 5+) PRIVATE (DESSERT INN) COOK 18. Mothar's Name (First, Middla, Maidan Surnama) 17. Fether's Name (First, Middla, Last) JOHN DUCKETT SR. ELSIE (ROBINSON) DUCKETT 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Pnint) 8302 GIBBONS DRIVE FORT WASHINGTON, MD JAMES DUCKETT SR. / SON 20b. Place of Disposition (Name of camatary, cramatory or other placa) 20c. Location - City or Town, Stata 20e. Method of Disposition 1 Buriai 2 Cramation 3 Ramoval from Stata ST. MATTHEWS CHURCH CEM. 3/5/99 NEWTON, MARYLAND 4 Donation 5 Other (Specify) 21. Symular of Funaral Service Licensee 22. Nama and Address of Fecility THORNTON FUNERAL HOHE, P.A. 3439 LIVINGSTON ROAD INDIAN HEAD, MD LYDIA C. THORNTON JOANSON 20640 23a. Part1. Entar tha disaasa, or complications that caused the death. Do not entar the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** SEPSIS /Medical Immediata Cause (Final disaasa or condition rasulting in daath) Examine Dua to (or as a consequence of): Examine OF LEFT JANGRENE physician and s the burial-trans Sequentially list conditions, if eny, leeding to Immediate causa. Enter Underlying Cause (Diseasa or Injury that initiated avants rasulting in death) Last Dua to (or as a consequanca of): VASCULAR ERICHERM Physician/Medical Due to (or es e consequance of) as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown KENAL DISEASS 2 24b. Wara autopsy findings available prior to completion of causa of daath? 24a. Was an autopsy Completed NEUMONIA 2 X No 1 ☐ Yes 1 Yas 2 No director. 25. Was casa rafarrad to medical axaminar? 26. Placa of Daath (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 0 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA 28a. Data of Injury (Month, Day Year) funeral 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? Certification: Neturel 5 Panding 1 Yas 2 No invastigation 2 Accident 6 Could not be detarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At home, farm, straet, factory, office building, atc. (Specify) 4 Homicida 10 Gertifying Physician: To the best of my knowledge, death occurred at the tima, data and placa, and due to the causa(s) and mannar as stated.
2 addical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the tima, date and placa, and due to the causa(s) and mannar stated. 29a. Certifier Medical (Check only one)

law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, for use as signed by the a d be detached f certificate has b Attending Physician: death. a Euneral Director: Joletely filled in by the ŏ pletely Te the Te within 2

death with the Maryland

Baltimore, Maryland 21215-0020

State Registrar 29b. Signature and titla

ENKAT

· S. CAMANAN 7501 32 Registrar's Signatura

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30. Name and address of parson who complated ceuse of death (Item 23a) (Type, Print)

SURRATTS (400)

29c. Licansa number

29d. Data signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day **Physician** BEULAH CECELIA DUNNINGTON FEBRUARY 27,1999 12:05AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 5340 NELSON POINT ROAD INDIAN HEAD CHARLES If Under 1 Yaar If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplaca (Stete or Foreign Country) **Funeral** 1□M 2XX Months Days Hours Yrs. 63 **Director** 211-26-8000 FEB. 28, 1935 MARYLAND Usual Rasidance of Dacedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner next be notified at 1 ☐ Yes 2 No Directo MARYLAND CHARLES INDIAN HEAD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 5340 NELSON POINT 20640 UNITED STATES Funeral death 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian. Black, White, etc. filed within 72 hours efter Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 200No Specify: by 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedant's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Flamentary/Secondary (0-12) College (1-4or 5+) 10TH GRADE HOUSEWIFE PRIVATE other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event, DRGs. 18. Mother's Name (First, Middle, Maidan Sumama) 17. Father's Nama (First, Middle, Last) JOHN DENT KATIE MARGARET PROCTOR DENT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, Stata, Zip Code) 5340 NELSON POINT ROAD, INDIAN HEAD, MD 20640 PAUL DUNNINGTON / HUSBAND 20b. Place of Disposition (Neme of camatary, crametory or other piece) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HOPE BAPTIST CH. CEM. 3/3/99 NANJEMOY, MARYLAND 21. Signiture of Funeral Sopvica Licensaa 22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. YOLA C. THORNTON JOHNSON MO0583 8439 LIVINGSTON ROAD, INDIAN HEAD, MD. 20640 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or haart failura. List only one cause on each line. Approximate Interval Batween Onsat and Death **Physician** Immediata Causa (Final disease or condition resulting in death) /Medical BREAST CANCER Examiner Due to (or as e consequance of): Examiner sician end burial-transit certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequenca of): ettending physician for use es the buna Box 68760. Physician/Medical Dua to (or as a consequence of): requires that the death ed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificent conditions contributing to death but not resulting in the underlying causa given in Part I. o 1 Yes 2 No 3 Probably 4 Unknown ۵ signed t Records, by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed peen completion of cause of death? The law certificate has 1 Yas XXNo 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was casa rafarred to medical axaminar? Be 26. Placa of Daeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this After thi funeral 28a. Data of Injury (Month, Dey Yeer) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Symural 5 Panding 1 Yes 2 No death. investigation 2 Accident 24 hours after deat Funeral Director: 6 Could not be datarmined 3 Suicida 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 | Homicida Hospital 29a. Certifier 1 🔀 🕳 ortifying Phyalcian: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. edical pletely (Check only one) 2 Madical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licansa number Tall D28352 MARCH 1, 1999

Registrar

32. Aegistrar's Signatura

P.O. BOX 2729, LA PLATA, MD

20646

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KRISHAN MATHUR, MD.,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

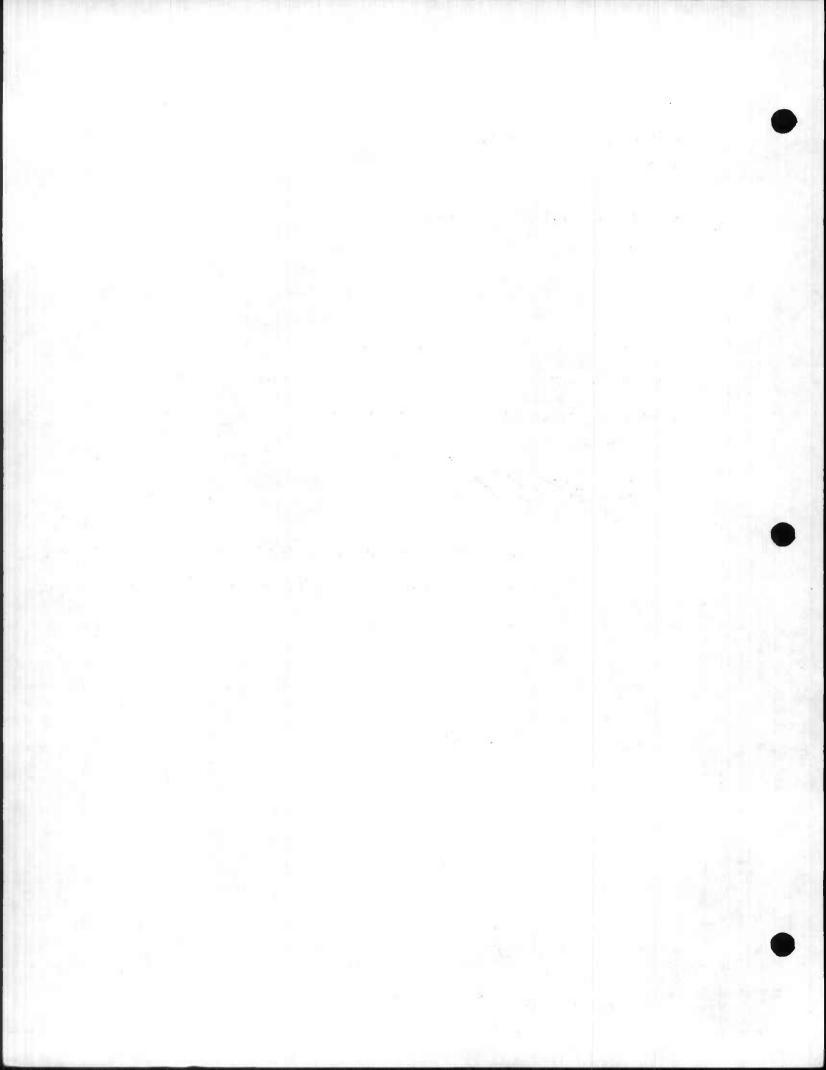
State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month Betty Jean DAVIS 3:43 DM larch /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Washington Washington County Hospital 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 200 F 68 Yrs. 215-26-8855 Director Jan.8,1931 West Virginia Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow other traumatic avent, the Medical Examiner must be notified at 1X Yes 2 No Director 28a-f Maryland Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? natural, or items 23a or 21740 USA 151 King St. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Meritel Stetus 1 ☐ Never Merried 2 ☐ Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 ※ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Heelth and Mentel Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic avent, the Mentel Injury or other traumatic avent, the Mentel Injury or other traumatic avent, the Mentel Injury or other traumatic avent, the Mentel Injury or other traumatic avent, the Mentel Injury or other traumatic avent, the Mentel Injury or other traumatic avent, the Mentel Injury or other traumatic avent. Elementery/Secondery (0-12) College (1-4or 5+) Utility Tele. Co. Telephone Operator 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Jesse James Turner Clara Agnes Helsey 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 151 King St. Hagerstown, MD 21740 Robert N. Davis/Husband 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete ₩ Buriel 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Lawn Mem.Park Mar.8,1999 Hagerstown.Maryland 22. Name end Address of Fecility
Osborne Funeral Home 21. Signeture of Funeral Service Licensee 425 S.Conococheague St. Williamsport, MD 21795 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one cause on each line. **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner HTNEROSCIEROTIC Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Bug Due to (or es e consequence of) P.O. Box 68760. · DIARETES MERLITUS Physician/Medical Due to (or es a consequence of) Pert II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yea 2 ☐ No 3 Probably 4 Unknown P 24b. Were autopsy findings available prior to Completed 24e. Wes an autopsy performed? HEART FAILURE completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Attanding Physician: 8 25. Wes case referred to medicat examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 ☑ Natural 2 ☐ Accident 5 Pending death. 1 Yes 2 No investigetion after death Director: 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) To the Hospital or A within 24 hours after To the Funeral Directomplataly filled in by 4 Homloide ACCITIFYING Phyalcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29e. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D38892 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 50,7E HAGERSTOWN, FOX BRANFORN 11110 MENIC 31. Date filed (Month, Day, Year) MAR 0 8 1999 32. Registrar's Signature

DHMH 16 Rav 6/95

State Registrar

Jean



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Dey **Physician** March 11:05 Partap Chander DHIR /Medical 4c. County of Deeth 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Sociel Security Number Birthplace (State or Foreign Country) **Funeral** Months 1X M 2 □ F Yes 63 Director Oct. 3 1935 579-56-2494 India Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17964 Garden Lane 21740 U.S.A. Funeral Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Maritel Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: p 3X Widowed 4 □ Divorced Indian "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Physician Self employed 12 11 other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 end 2 should be filk Department of Health end Mental Hy Important: If Itan 27 Ia marked oth any Injury or other traumatic avant abca. Be Nand-Rani Sushila Puri Chimanlah Dhir 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Desiree Sheridan - Daughter 103 Heatherdell Road Ardsley, New York 10502 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Buriel 2 【XCremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Hagerstown Crematory 3-5-99 Hagerstown, Maryland 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Minnich Funeral Home Vistal 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heer failure. List only one cause on each line. Onset and Death **Physician** /Medical Immediate Ceuse (Finel Myocardia disease or condition resulting in deeth) Examiner abetere mell Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es a consequence of): neer moni q Physician/Medical Due to (or es e consequence of): 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Zench þ 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Wes en eutopsy has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? Division Attending 1 PNetural 5 Pending investigation death. 1 Yes 2 No 2 Accident Director: 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in by after 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and menner stated. edicai 29a. Certifier (Check only one)

State Registrar 29b. Signature and title of certified

31. Dete filed (Month, Day, Year)

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32. Registrar's Signature

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print)

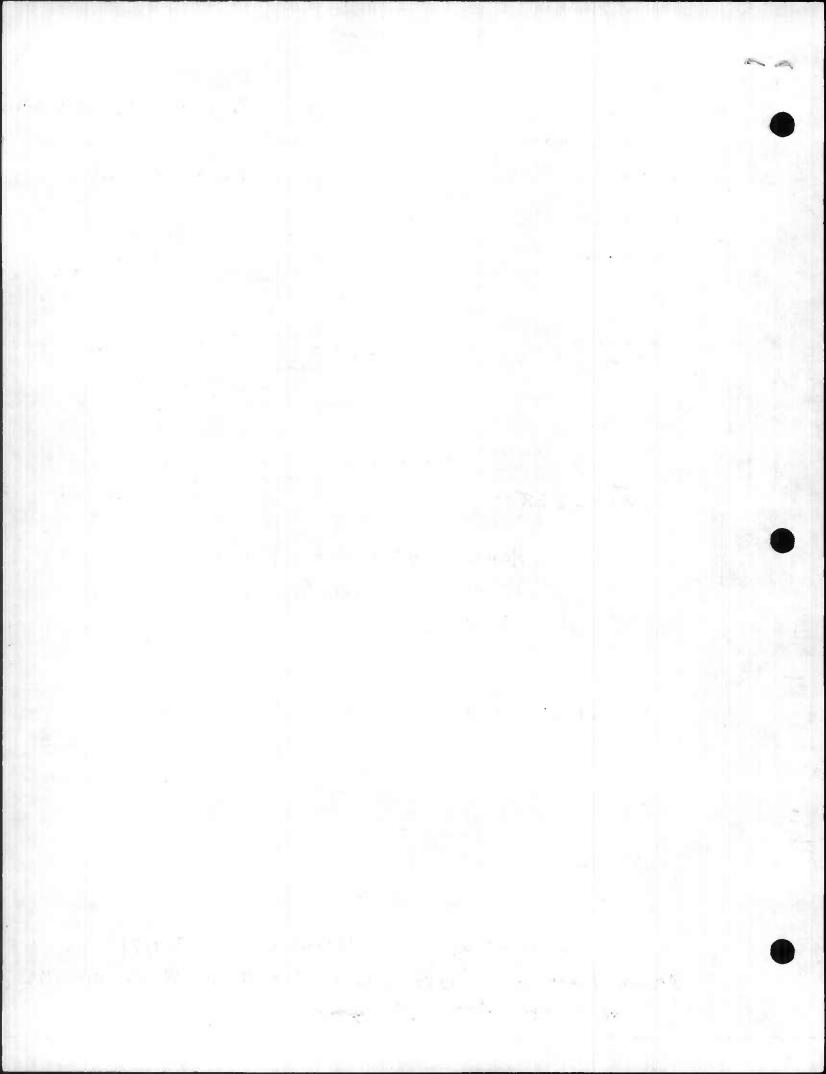
WAHEER UD

MAR 0 5 1999

29c. License number

12821-OAKHILAVE. HAGERSTOWN-MD 21742

29d. Date signed (Month, Day, Year)



Maryland

Specify:

3. TIME OF DEATH 5:30

10d. INSIDE CITY

1 YES 24 NO

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Approximate

24b. WERE AUTOPSY FINDINGS

1 TYES 2 10 NO

29d. DATE SIGNED (Month, Day, Year)

AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?

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hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

Pages 1, 2, 3 should

permit.

detached for use as the burial-transit

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should b	
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HATURE AND TITLE OF CERTIFIER

31. DATE FILED (MORIN, Day, Year) MAR 0 9 1999

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32. REGISTIAR'S SIGNATURE

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH Fred Junior DAYHOFF March 5, 1999 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs, last birthday) 7. DATE OF BIRTH B. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. June 26, 204-34-0243 1 🕅 M 2 🗌 F 60 YRS. NOURS 1938 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 19810 Evelyn Avenue Hagerstown Washington DIRECTOR RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a. STATE 10b. COUNTY Washington Maryland Hagerstown FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21742 19810 Evelyn Avenue U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yea or Noif yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. RACE — American indian, Black, White, etc. 1 Never Married 2 Married 1 WES 2 NO Specify: BY 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION secify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) ndary (0-12) 0-11 chemical co. trucker 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Frederick William Dayhoff Viola Gertrude Domer F BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 19810 Evelyn Avenue, Hagerstown, Maryland 21742 Ms Joan Hurd/companion must be 20e. METHOD OF DISPOSITION

1 Surial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Rest Haven Cemetery Hagerstown, Maryland 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 medical 23. PARTIC. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haert failure. List only one ceuse on each line IMMEDIATE CAUSE (Final the disease or condition resulting in death) event. traumatic vias CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): thet initiated eventa resulting in deeth) LAST 6 Injury. PART II. Other aignificent conditione contributing to death but not resulting in the underlying cause given in Pert i. 24s. WAS AN AUTOPSY MEDICAL flicities any 1 YES 2 NO shows : Greensin DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 4 ☐ Nursing Home 5 Residence 8 ☐ Other (Specify) 0 27. MANNER OF DEATH 26e. DATE OF INJURY (Monthy Day Year) 28b. TIME OF 26c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending investigation M 1 YES 2 NO BY 2 Accident DIRECTOR: After hours after deal 28a. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) hours after dea 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29e. CERTIFIER
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and menner as stated.

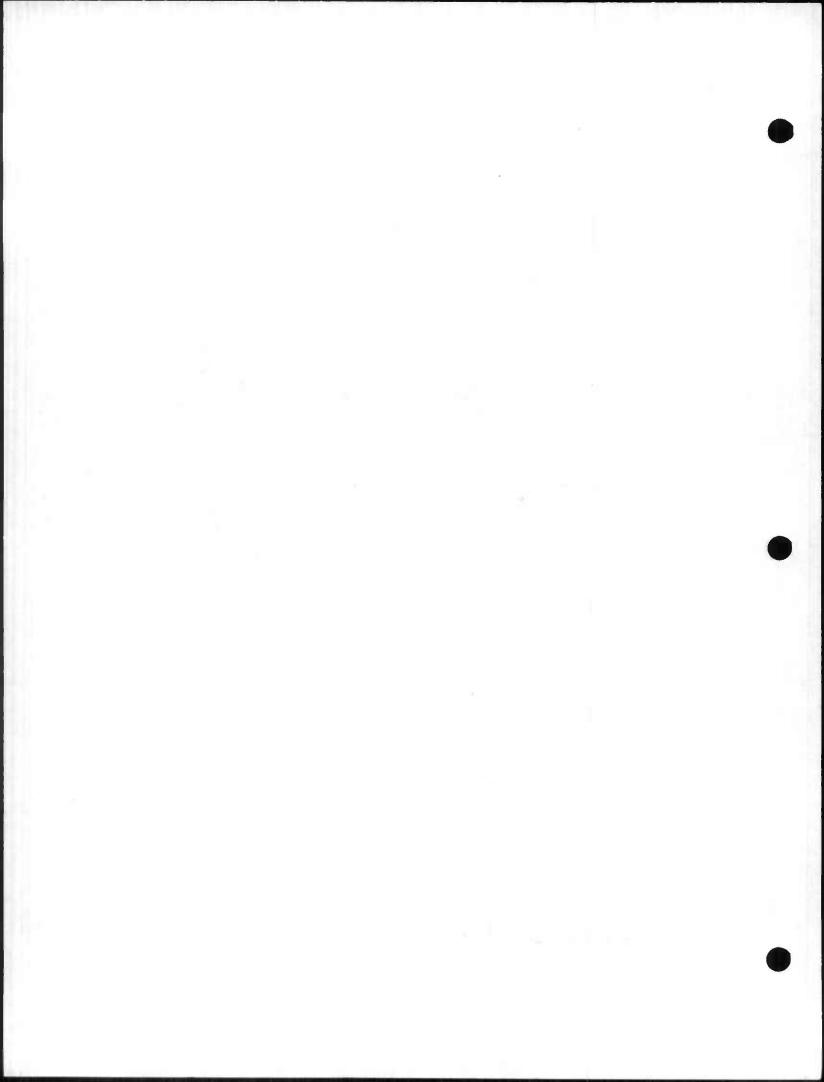
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated.

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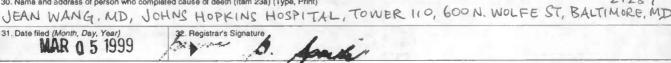
29c. LICENSE NUMBER



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day **Physician** 5.00AM LORIMER FLWELL Marcha D. /Medical 4b City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Altimore Hopkins Hospital Johns If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthdey) 9. Birthplece (Stete or Foreign 5. Social Security Number **Funeral** Deys 1 X M 2 □ F Months ALABAMA 332-26-1327 Director 73 OCT 23,1925 Usuel Rasidence of Dacedent with the Maryland 10d. Inside City Limits 10e State 10h County 10c. City. Town or Location r 28a-f show VIRGINIA FAIRFAX SPRINGFIELD 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? "natural", or Items 23s or 6716 HOLFORD LANE 22152 filed within 72 hours after death Funeral S A 14, Rece - American Indian, 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status Black, White, atc. 1 Navar Merried 2 Merried Specify: WHITE 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 ģ 3 ☐ Widowed 4 ☐ Divorced h and Mental Hygiena.
7 Is marked other than "natur traumatic event, the Western 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondary (0-12) ASSISTANT ADMINSTRATOR DEPT. OF AGRICULTURE 18. Mothar's Nama (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Heelth and Mental Hy ant: If them 27 is marked oth lury or other traumatic event LORIMER D. ELWELL SR WINIFRED RUTLEDGE 19a. Informant's Name/Relationship (Type, Pnint) 19b. Malling Addrass (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) BERNICE M. ELWELL 6716 HOLFORD LANE, SPRINGFIELD, VA 22152 20b. Plece of Disposition (Name of 20e. Method of Disposition 20c. Location - City or Town, State Buriel 2 Cremation 3 Removal from State 4 Donetion 5 Othar (Specify) QUANTICO NATIONAL CEM. 3/5/99 QUANTICO, VIRGINIA 22. Name end Address of Facility 21. Signature of Funeral Service Licensee DEMAINE FUNERAL HOME, 520 S. WASHINGTON ST., an 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrests shock, or heart failure. List only one cause on each lina. Approximate Interval Between Onset and Deatl **Physician** /Medical Immediata Cause (Finel HYPERCALCEMIA DAYS disease or condition resulting in death) Examine Due to (or as a consequence of): Examiner MULTIPLE MYELOMA YEARG The law requires that the death certificate be executed physician and s the bunal-trens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaasa or Injury that initieted evants rasulting in deeth) Last Due to (or as a consequence of) YEARC Division of Vital Records, P.O. Box 68760, AMYLOIDOSIS Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed l by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy bloods Completed performed ate has 2 No 1 Yes 1 TYas 2 No certificate or Attending Physician: director Be 25. Was case referred to medical 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Dey Yeer) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 Yes 2 No death. Director: A 2 Accidant 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Spacify) efter o 4 Homicida hin 24 hours efter the Funerel Dir empletaly filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Cartifiar Medical (Check only one) To the To the Complet 29d. Data signed (Month, Dav. Year) 29c. License number 29b. Signature and titla of certifier

31. Date filed (Month, Day, Year) MAR a 5 1999 Registrar



MD

30. Nama and addrass of person who complated cause of deeth (Itam 23a) (Type, Print)

2, 1999

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State of Maryland / Department of Health and Mental Hygiene 9 9 08750

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by E.	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forcas? 1 ☐ Yes 2 10 No If Yes, Giva Yaar or Datas:	U,S.	13. Was Dece If Yas, spe	cify Cuba	ispanic Ori an, Mexican Specify:	gin? (Specify) i, Puarto Rican	(es or No- , atc.)	Blac	e - Amarica k, Whita, a :White	atc.	
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trau	Sharon Boulet/Nie								liforni			
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DUCE	4 Donation 5 Other (Specify) 21. Signatura of Funaral Service Licensee 22. Nama and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, MD 2076											
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Me Me	29b. Signatura and titla ot certifiar	^	-	29	c. Licens	e number	1	2	9d. Data signed	d (Month,	Day, Year)	
()	1110000	Colour un		-	11.1	79			2/27/9	9		
7/	30. Nama and address of parson who o	completed cause of death (the	om 23a) (Tu	rpe, Print)	0 (4)	4			-	/		
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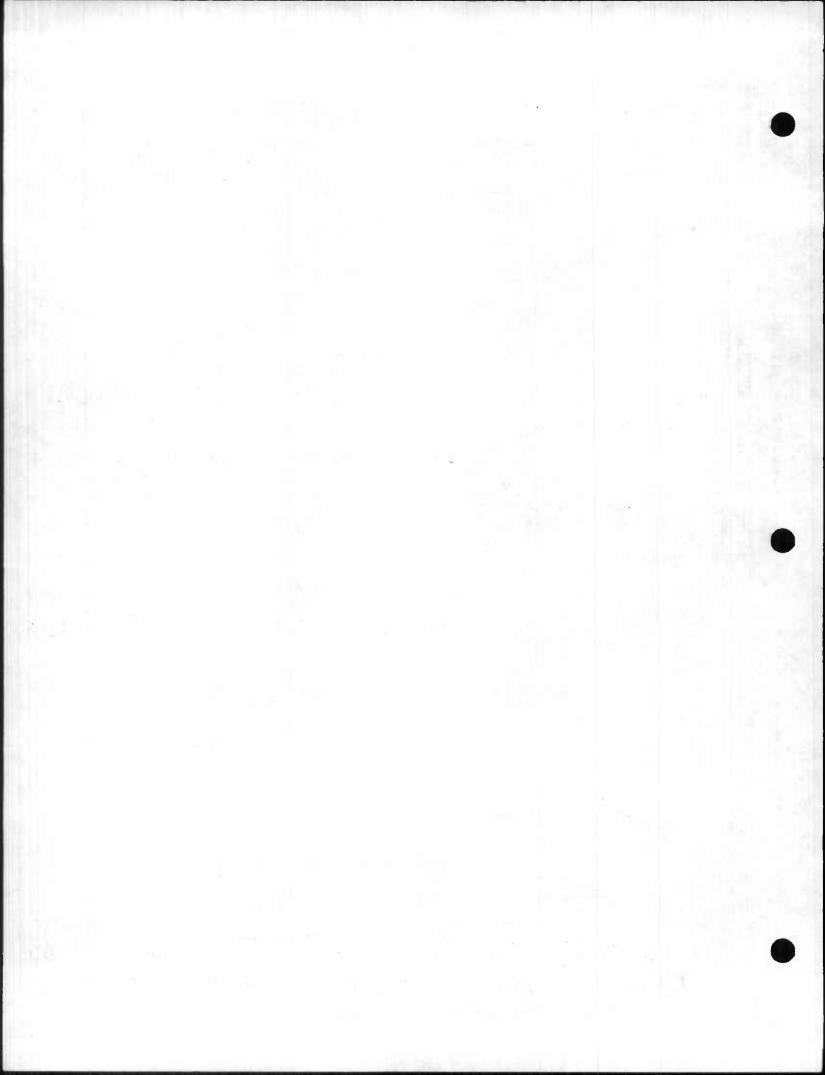
State of Maryland / Department of Health and Mental Hygiene 9

						Ce	rtificate d	of Death	7	Re	eg. No.			
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	/Medica Examine		4e Facility Name (If not institution, give			C_III.dd	ICRUGII_			ation of Death	4c. Count	of Death	90.0	
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	show		10a. State 10b. County 10c. City, Town or Location							10d. Inside City Limits 1 ☐ Yes 2X No.				
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	Po I	5	10e. Street and Number				10t. Zip Cod	Se .		1	Og. Citizen of		try?	
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41415-0040	chous after open with the meryand at Estanties must be notified at ed by Funeral Director	6	11. Marital Status 1 Never Merried 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Pue						ity Yes or No- ican, etc.)		ck, White,		
	72 ho	matura Meal E	15. Decedent's E	ducation	16a. Dece	dent's Usual Oc	cupation	at all working		16b. Kind of B	usiness/Ind	dustry		
7	od within 72 ho ygiene. or than "naturit, Tra Haucalit, Completed	9	(Specify only highest gra Elementery/Secondary (0-12)	de completed) (Give kind of work done during most of work life. DO NOT use retired)										
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		2	3 Suicide 6 Could not be determined	286. Place of in			reet, tactory, off	ice	21	Bt. Location (St City or Town	reet and Numi	ber or Rure	l Route Number	
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	within 2 To the comple	pite .	29b. Signature and title of certifier				29c. Lic	ense number		2	9d. Date signe	ed (Month.	Dey, Year)	
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		1	Name and address of person who	completed cause of	death (Ite	m/28a) (Type,	Print) X	14 12 1	11		A.	11 -	10.1	
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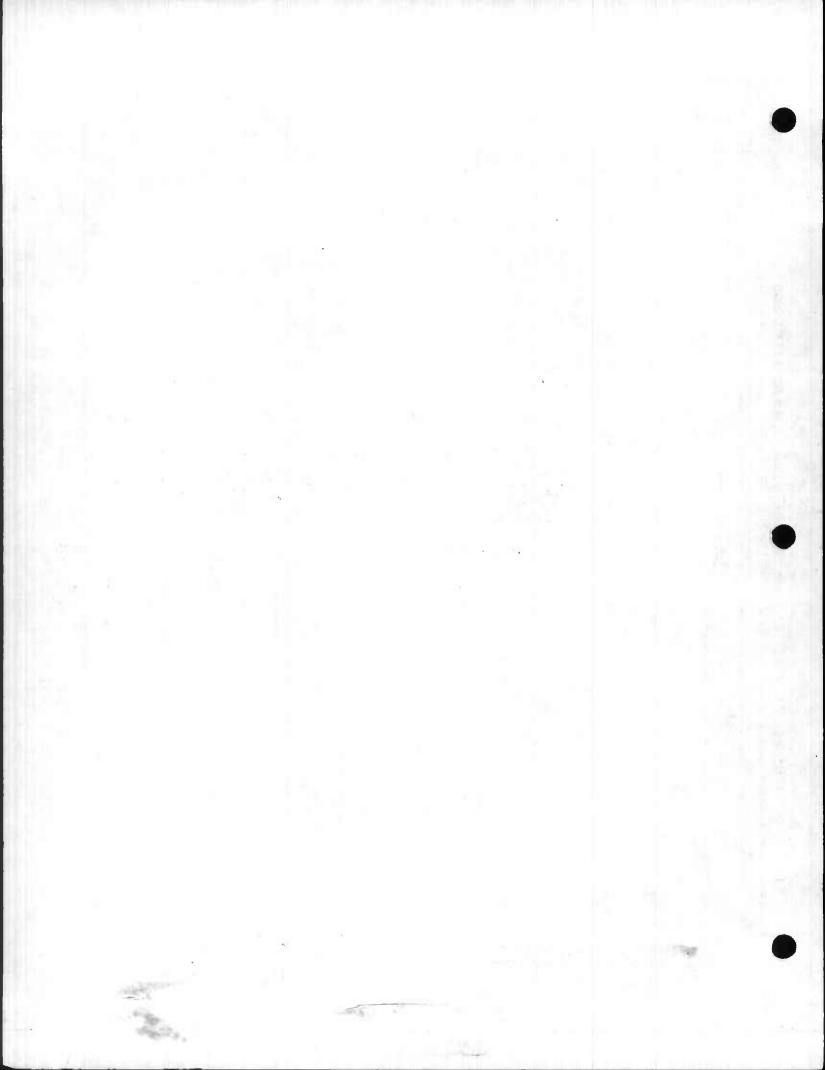
Irene Ellsworth



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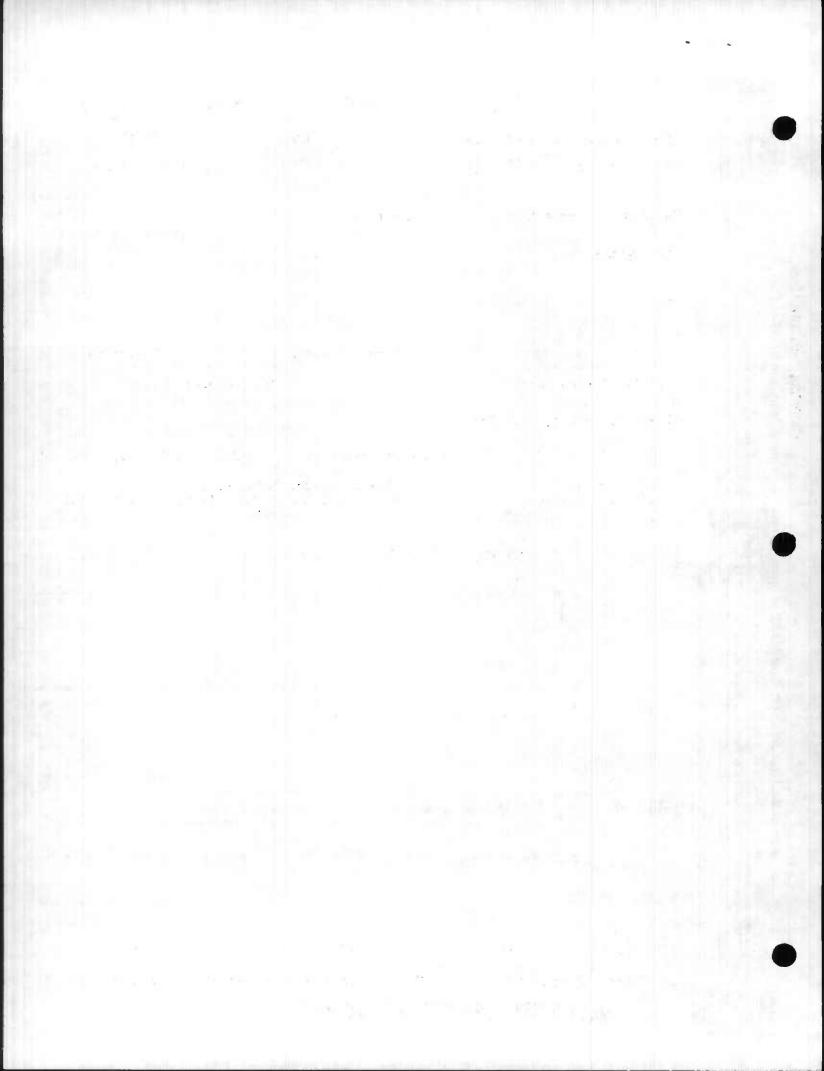
State of Maryland / Department of Health and Mental Hygiene 9 08752

				Ce	rtificate	of Death		Reg. No.	U	0/10	6-	
5	1. Decedent'a Name (First, Midd	le, Last)					2. Date of De Month		Vaar	3. Time of	Death	
Physician /Medical	Genevieve M. Ev	ans					Februar	y 25,	1999	9:40	AM	
Examiner	4a Facility Name (If not institution	n, give street and number	er)			4b. City, Town, or	Location of Deat	h 4c. County	of Death			
4,4	Holy Cross Hosp	ital				Silver S	Spring	Mor	ntgome	ery		
Funeral Director	5. Social Security Number 476-12-4638	6. Sex 7. 1 M 2	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Months I	Year If Under 24 Hr. Days Hours Mir		th Year) 1912	9. Birthp Coun Iow	lace (Stata d try) va	or Foreign	
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ter death with the Maryland items 23s or 28s-f show inst.must.be.notified.at Funeral Director		e Road			10f. Zip Co	20905		USA	What Coun	try?		
72 hours after death vinatural, or items 23st ileal Examiner must sted by Funeral	3 ☐ Widowed 4 ☐ Divorced	If Yes Give	os? ☑ No			t of Hispanic Origin? (Cuban, Mexican, Pue I No Specify:	Specify Yas or No rto Rican, etc.)	14. Rad Bla Specif	ck, White, white			
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within within the Max omple	Elementary/Secondary (0-12)	College (1-4c	or 5+)		e Assi	done during most of w retired) Stant	Anny	Be	verag	e		
Hygin Hygin ent. I		Last)	1			18. Mother's Na	ame (First, Middle	, Maiden Sumar	ne)			
yiand wental H wheel off white off white ever	Marinus Ch	ristensen					Mary Mag	uire				
C SOUTH P	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailie	ng Address (5	itreet and Number or F	Tural Route Numb	er, City or Town	State, Zip	Code)		
	Milton J. Evan	s/Husband		15124	Water	gate Rd.,S	ilver Sp	ring, M	D 209	05		
6 - F - F	20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Name							
altimore, mit. Pages 1 a partment of Hse portant: if Hsm. y injury or othe	1 🖾 Burial 2 Cremation 4 Donation 5 Other (S		16	e of H	f Heaven Cemetery 3/1/99 Silver Spring,							
Depart Depart Import eny in	21. Signature of Funeral Service	Licensee				Address of Facility Fr c. 500 Un pring. MD		Collin Blvd.,	s Fun West	eral		
	Silver Spring, MD 20901 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
Physician												
/Medical	disperse of Condition											
Examiner	resulting in death)	8. COTO	8. Due to (or as a consequence of):							mont		
je de la companya de		Pneur		as a consec	querice ory.			12	week	S		
ba / bu, licate be executed physicien and s the burlat-transit edical Examiner	Sequentially list conditions, if any, leading to immediate	b	Due to (or	as a consec	quence of):							
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The law ate has be page 2 s	1000		10									
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To the Hospital or Attending Physician: The law within 24 bours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	27. Manner of Death 1 ②Natural 5 □ Pendir 2 □ Accident investi	28a. Date of li (Month, i		28b. Time o Injury		Injury at Work?	-	how injury occur		,		
DIVISION C tail or Attending P rs after death. el Director: Attert led in by the funers Certification:	3 Suicide 6 Could 4 Homicide determ	nined 288. Place of	Injury - At ho etc. (Specify	me, farm, str	reet, factory, o	ffice		(Street and Num wn, State)	ber or Rura	I Route Nun	nber,	
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15	> Clean	Geonond	1-		1	24245		February	26,	1999		
	30. Name and address of person 10801 Lockwood					Ala	n Diamor	nd, MD				
State	31. Date filed (Month, Day, Year)	32. Regi	etrar's Signat	ure					-			
Registrar	MAR 01	1999	epera	19.	600	alls!						



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	1. Decedent's Name (First, Middle, Last,					2. Dete of Dee Month	eth Day	Year	3. Time of Death
Physician /Medical	Elizabeth A	pplegart	h Mace	Farver		Mar.	6 19	99	7:55 p
Examiner	4e Facility Neme (If not institution, give	street and number)			4b. City, Town, or	Location of Deeth	4c. County	of Deeth	
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Funeral Director	219-30-7123	7. Age	(In yrs. last birthe Yr	Months Dev			, Year) 1910		lece (State or Foreig try) Land
show dat	Usuel Residence of Decedent 10e. State 10b. County		10c. City, Town o					10	0d. Inside City Limits
or 28a-f s be notified Director	Maryland Dorches	ster	Ca	ambridge					1)(CYYes 2 □ No
Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhet Coun	try?
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t, the Medical I	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) 16e. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)					rking	16b. Kind of Bu		
	11 17. Father's Name (First, Middle, Last)	4		School Te		me (First, Middle,		catio	onn
ad off	William Irving Ma	ace				ny Crowe			
To	19a. Informent's Name/Reletionship (Ty		19b. A	Mailing Address (Stre				*	Code)
27 is r trau	Albert S. Farver,			1708 River					
Pages 1 an vent of Heat mt: if them 2 ny or other	20e. Method of Disposition		20b. Plece of D	Disposition (Neme of cremetory or other p.		Date	20c. Location -		wn, Stete
TY OF	1 ☐ Burial 2 ☐ Xremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)			ury Cremat		3/8/99	Salisbu	rv. N	Maryland
orte in e	21. Signature of Funeral Service Licanso			22. Name and Add	ress of Facility		Justinou	- / ,	ar y rand
of the second	> W			Thomas Fu	neral Hom	ne, P.A.			01610
	23a Para Enter the disease, or compli	ications that caused th	he death. Do no	700 Locus	Ing, such as cardia	c or respiretory er	rest,	Tand	Approximate Intervel Between
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/Medical	Norbert Franke				th City Town or I	2		79	0700
Examiner Funeral Director	4a Fecility Name (If not institution, give 7106 River Cres of 5. Social Security Number 579-52-8304 6. Se	cent Drive		Under 1 Year onths Days	Annapoli If Under 24 Hrs. Hours Min.	s		9. Birthole	n de 1 ace (State or Foreign ry) ., D.C.
P	Usuat Residence of Decedent	l in a							
show allow	10a. State 10b. County		ty, Town or Location					10	d. Inside City Limits 1 Yes 2 No
Ba-f outfile	Md. Anne Art	indel A	Annapolis				40.00		
Dir Dir	10e. Street and Number	5 D.	· ·	Of. Zip Code	1		10g. Citizen of W		ryr
erai	7106 River Cres		Was Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes if Yes, specify Cuben, Mexicen, Puerto Rican, el Yes, Sive Year or Dates: 1940 − 70 16a. Decedent's Usuel Occupetion			pecify Yes or No	US	- America	n Indien.
Nore, Maryland 21215-0020 ges 1 and 2 should be filed within 72 hours efter deeth with the Meryland to f Heelth and Mental Hyglene. If itam 27 is marked other than "natural", or itams 23a or 28e-f show or other traumatic event, the Medical Expriner must be notified at To Be Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No							tc.
1 21215-0020 led within 72 hours of tyglene. ner than "natural", or ner than "natural", or ner than "completed by F	15. Decedent's Edu (Specify only highest gred Elementary/Secondery (0-12)	icetion (e com <i>pleted)</i>				16b. Kind of Business/Industry		ustry	
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ore, IV	Suzanne Frankenber 20a. Method of Disposition		7106 Ri		escent Di	Date Ar	napolis		
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Physician /Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death) REALICA								142
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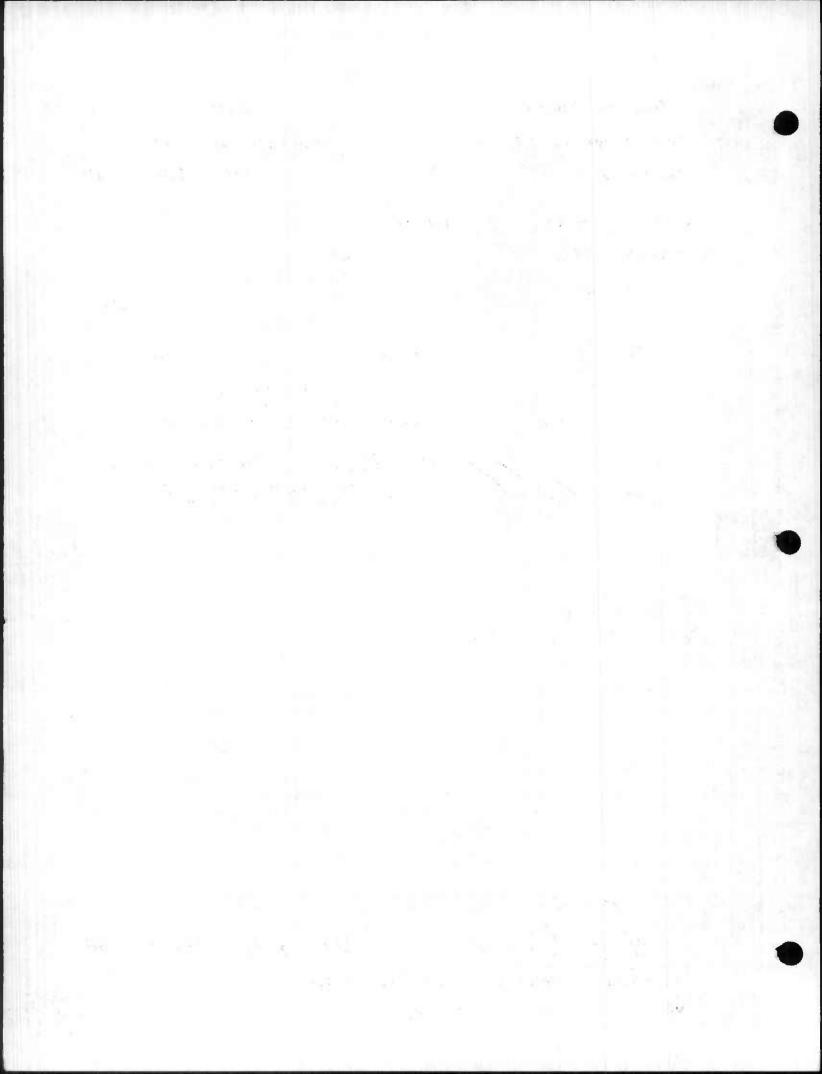
State of Maryland / Department of Health and Mental Hygiene O

Certificate of Death 1. Decedent'a Name (First, Middla, Last) 2. Dafa of Death 3. Time of Death **Physician** FEB. 25 Day 1999 EVELYN N. FISHER 1:20PM /Medical 4a. Facility Name (If not Institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 450 POPLAR LEAF DRIVE EDGEWATER ANNE ARUNDEL If Under 1 Yaar If Undar 24 Hrs. Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) **Funeral** Months Days 1 ☐ M 2 🖔 F Yrs Director 225 10 9016 83 JAN. 6, 1916 VIRGINIA Usuai Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. inside City Limita 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 20 No Director MARYLAND ANNE ARUNDEL **EDGEWATER** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 Nerns 23a permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or items 23a eny Injury or other traumatic event, the Medical Examiner mans once. 450 POPLAR LEAF DRIVE 21037 UNITED STATES Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Mexican, Puarto Rican, atc.) 14. Race - American indian, Black, White, atc. 1 ☐ Yas 2XXNo If Yes, Give Yaar or Dates: 1 Nevar Married 2 ☐ Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 No by Specify: WHITE 3.☐Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 0 DIETICIAN FOOD 17. Fathar's Nama (First, Middle, Last) 18. Mother'a Name (First, Middle, Maiden Sumama) Be FRANCIS J. BOHM EULA McCRAY 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDNA PERKINS (EXECUTRIX) 3565 SOUTH RIVER TERRACE EDGEWATER, MD. 21037 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramovai from State 4 ☐ Donation 5 ☐ Other (Specify) 03-01-99 ROANOKE, VA. BLUERIDGE CEMETERY 21. Signature of Superal Service License 22. Name and Addrass of Facility JOHN M. TAYLOR FUNERAL HOME, INC 21401 147 DUKE OF GLOUCESTER ST. ANNAPOLIS, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervai Between Onset and Death **Physician** immediate Causa (Final disease or condition resulting in death) /Medical cancer Examiner Due to (or as a consequence of): Physician/Medical Examiner ician and buriai-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in deeth) Last Dua to (or as a consequence of) physician s the burial Box 68760. Due to (or as a consequance of): 88 attending 980 P.O. Part II. Other significant conditions confributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be datached YYee 2 No 3 Probably 4 Unknown Division of Vitai Records. à 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 s has 1 Yes 2 No 1 □ Yes 2 □ No certificate or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 TYAS 2 TANO 1 | Inpatiant 2 | ER/Outpatient 3 | DOA After this funarai 27. Menner of Death 28a. Date of injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. injury at Work? Naturai 2 Accident 5 Pending Investigation death. 1 Yes 2 No hours after death 6 Could not be determined 3 ☐ Sulcide within 24 hours after de To the Funeral Directo completaly filled in by th Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a, Cartifier Medical To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 99 005323 30. Name and address of person who pleted cause of death (item 23a) (Type, Print) DARRYL HILL M.D. 2003 MEDICAL PARKWAY SUITE 100 ANNAPOLIS, MD. 21401 31. Data filed (Month, Day, Year) MAR 0 32. Registrar Signatura State 1999 B. Sparks Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Decedant's Nama (First, Middle	le Last)			tificate of	Death	2. Data of Dec	Reg. No.	, 0	0 / (3 b
nysician		William Gary F						Month	Day	Yaar		of Death
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P		Coley Fulford					Lucy FA	Lowers				
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		Myrna Rice Ful	ford		4993	Lowland	d Rd., Lo	owland, N	IC 28552	2		
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cian/Medical Examiner		disaasa or condition resulting in death) Sequantially list conditions, fony, laading to Immadiata causa. Enter Undarlying Causa (Disaasa or Injury het Initiated evants rasulting in daeth) Last		farction Intervel Between Onset and De Syears				rs				
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	2	7. Mannar of Death 1. Natural 5 Panding 2 Accidant invastig	ation	of Injury oth, Day Year)	28b. Tima of Injury	28c. injur Wor M 1	yat k? Yes 2 □ No	28d. Dascribe h			-	
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		29a. Certifier 1 Certifying (Check only one)	g Physician: To the Examinar: On tha b and man	best of my kno asis of axamina anar stated.	owiedga, daath o ation end/or invas	occurred et tha tin stigation, in my o	na, data and place pinion, daath occu	, end dua to tha c irred et tha tima, d	ausa(s) and ma ata and place,	nner as sta end dua to t	ted. ha causa	i(s)
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completely		O. Nama and address of person of H. Farkas, MD O. Marka and Address of Person of H. Farkas, MD				$\frac{D}{m}$, MD 21	921	4 1	Tarch	7,19		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Dav 0255 March Ella A. Finnefrock 05 1999 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Union Hospital Elkton Cecil If Undar 1 Yaar If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Feb 22 1907 Birthplaca (Stata or Foraign Country) Months Hours 1 M 2 F Deys 92 218-40-7044 Maryland Usual Rasidance of Decedant 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yas 2 No Cecil Rising Sun 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 736 Connelly Rd. 21911 U. S. A. 12. Was Decedant Evar In U,S. Armed Forcas? 1 ☐ Yes ≥ 2 M No If Yas, Giva Yaar or Datas: 14. Race - Amarican Indian, Was Decedant of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Maritel Stetus Black, Whita, atc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: 3 → Widowed 4 Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elementary/Secondary (0-12) Coilega (1-4or 5+) Homemaker Home. 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Clarence Alexander Cora Riley 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Shirley A. Powers, Daughter 736 Connelly Rd. Rising Sun MD 21911 20b. Place of Disposition (Nama of cematary, cramatory or other pleca) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata Pleasant Cemetery March 8 1999 Peach Bottom PA 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nema end Address of Fecility 21. Signature of Funeral Service Licenses R. T. Foard Funeral Home, P. A. 111 S. Queen St. Rising Sun MD restaro ter the disease, or complications that caused the heart failure. List only one cause on each line. Approximete Interval Batwaan Onsat end Daeth leath. Do not antar the mode of dying, such as cardiac or respiretory errest, Immediate Cause (Final disease or condition resulting in death) Cualom UOXUMA Due to (or as a cons Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy findings eveilable prior to complation of causa of daath? 24a. Was an autopsy performed? 1 Yas 2 No 25. Was casa rafarrad to madical 26. Placa of Daath (Check only one)

Physician /Medical

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Division of Vital Records.

Physician

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7 is marked other than "natural", or frame 23a or 28a-f show treumstic event, the Medical Examines must be notified at

permit. Fages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene.

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Baltimore, Maryland 21215-0020

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death

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28a. Deta of Injury (Month, Day Year)

28b. Tima of

28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)

Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify)

28c. Injury at Work? 1 Yas 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

28d. Describe how Injury occurred

29a. Cartifiar (Check only one)

3 Suicida

4 Homicide

Cartifying Phyalclan: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and titla of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and eddress of person who con

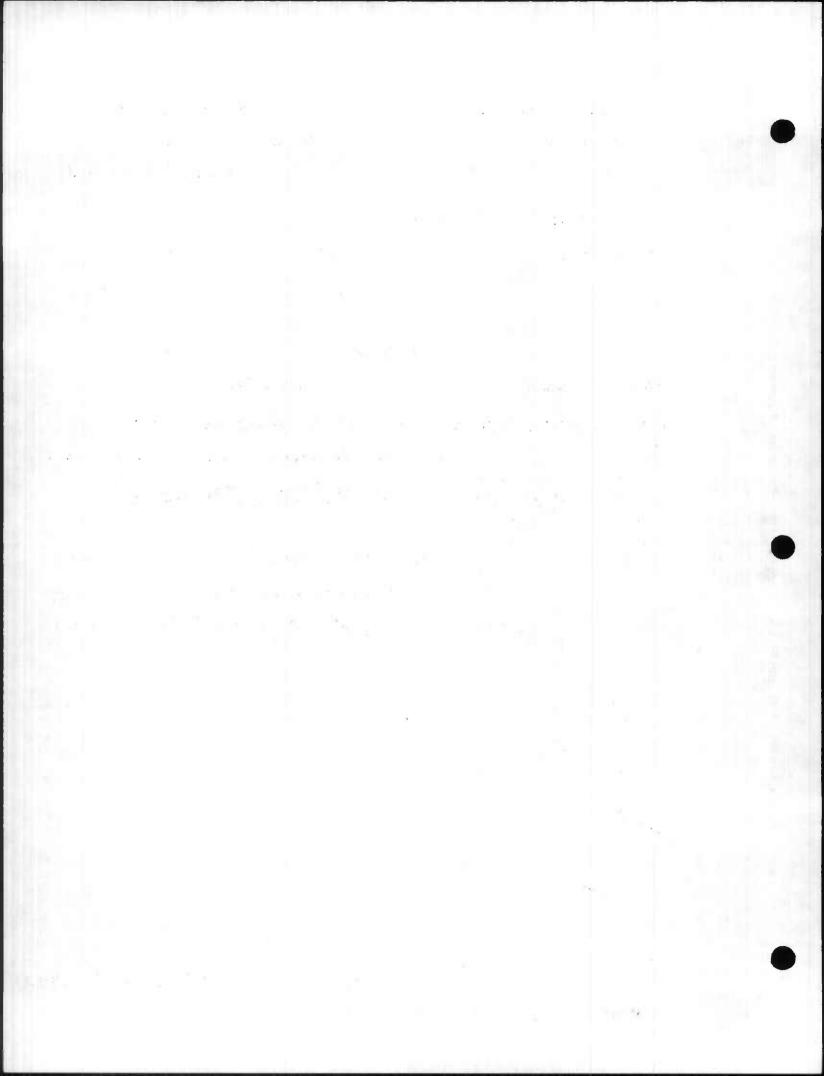
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32. Registrer's Signature

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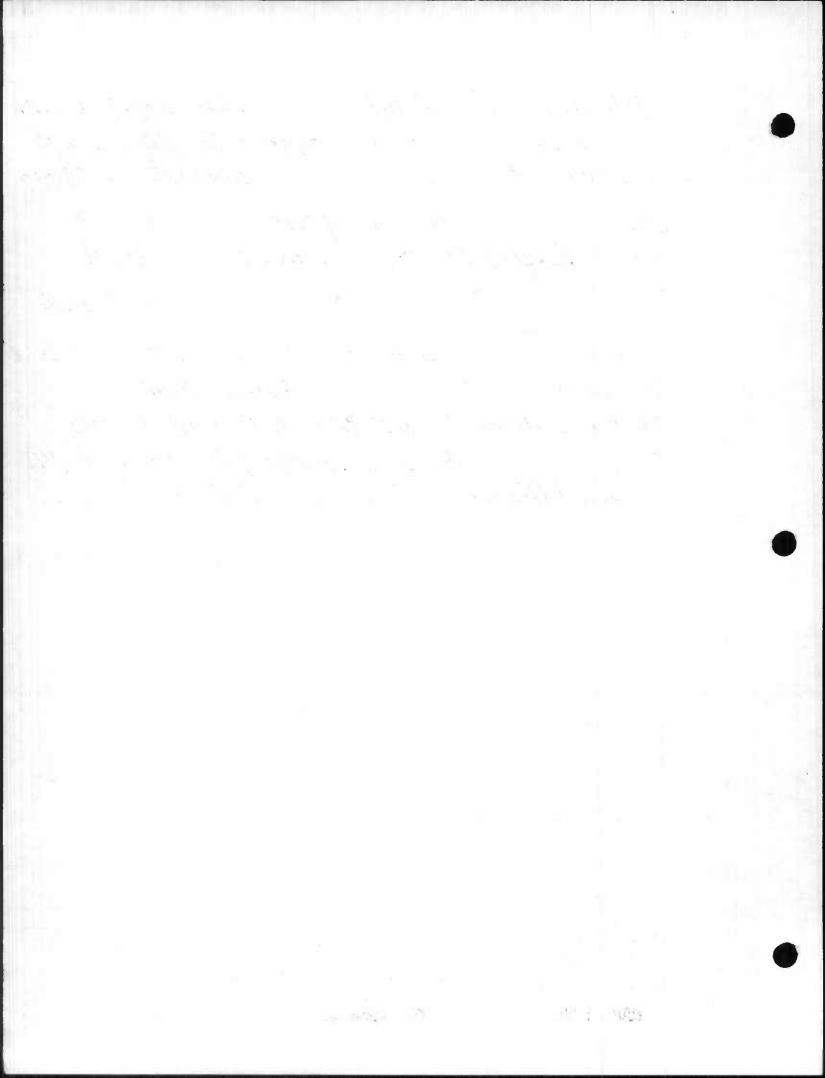
State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienes of

			tificate of Death		Reg. No.	3. Time of Death
Physicia: /Medica		FlORINE E FITC	h	FEB	12 1999	10:45 PM
Examine		4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	r Location of Death	4c. County of Death	
Euparol		S. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hi		9 Birth	PORGE Appliace (State or Foreign
Funeral Director		511-12-0104 1 M 2XF 78 Yrs.	Months Days Hours Mi	n. (Month, Day	Year) AZO CO	PRGINIA
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with the	Director	10e. Street and Number	101. Zip Code	9	10g. Citizen of What Con	untry?
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permit. Departimportu		Louis Illinus II	Name and Address of Facility	STERIII	190F.S.	10/2 (
		23a. Part1. Enter the disease or compilications that caused the death. Do not ente shock, or he in failure. List only one cause on each line.	r the mode of dying, such as cardi	ac or respiratory ar	rest,	Approximate
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/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) ASPIRAT		MON	iA	5 CAYS
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Attanding Physician: The law requires thet the death cent of death. ector: After this certificate hes been signed by the ettending by the funeral director, page 2 should be detached for use with the funeral director.	Completed	"PEG" FEEDING		248. Was	mod2 B	Vere autopsy findings valiable prior to completion of cause of death?
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ding in.	LIOU	27. Manner of Death 1 PNaturai 5 Pending 2 Accident investigation 28a. Date of injury (Month, Day Year) Injury	28c. injury at Work? M 1 Yes 2 No	28d. Describe n	ow injury occurred	
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	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or invegore)	occurred at the time, date and planstigation, in my opinion, daath oc	ce, and due to the courred at tha tima, o	ause(s) and manner as lata and place, and due	stated. to the cause(s)
of the of the omple	Me	and manner stated. 29b. Streature and little of certifier	29c. License number		29d. Date signed (Month	, Day, Year)
->-0		Alue!	219609		3.15-89	
		30. Name and address of person who completed cause of death (Item 23a) (Type, PRAMAN R. TULL, HD 3503 PERR	YSTREET MO			20712
State	9	31. Date filed (Month, Day, Year) MAR 1 5 1999 34. Registrar's Signature	1 -	4141 1911	71167	~
Registra	,	MAR 1 5 1999	Market			



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Registrar

MAR 0 5 1999

Market Unit America

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Day Leo Gerard Francisco February 25, 1999 9:10pm 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Prince George's Southern Maryland Hospital Clinton If Under 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 1 ★M 2 F Months Days Hours Yrs. 435-02-3269 42 Sept. 3, 1956 New Orleans, La Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Clinton 1 Yas 2 □ No Maryland Prince George's 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20735 United States 9911 Raintree Way 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Spacify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - Americen Indian, Black, Whita, atc. 11. Marital Status 1, Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yas 2□ No Specify: Spanish Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Government Educator/ Postal Worker 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Leo Paul Francisco Theresa Breaux 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Francisco / Wife 9911 Raintree Way Clinton, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ♣ Ramoval from State 3/5/99 4 □ Donation 5 □ Other (Specify) National Cemetery Baton Rouge, La. pf Funeral Service Licenses 22. Name and Address of Facility

Physician /Medical

Physician

/Medical

Examiner

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Funeral

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Completed

Funeral

Director

?7 is marked other than "naturel", or flams 23a or 28a-f show traumatic avent, tra Mayical Examinar must be normed at

with the Meryland

Examiner

Immediate Cause (Final disease or condition resulting in deeth)

Physician/Medical Examiner physician and s tha bunal-transit attending ph signed by the a by Completed

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Certification:

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The law requires that the death certificate be executed is certificate hes I director, paga 2 s To the Hospital or Attending Physician: within L24 hours after death.

To the Funeral Director. After this certifical complatally illied in by the funeral director,

Division of Vital Records, P.O. Box 68760,

Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest,

Approximate

Approximate Approximate Interval Between Onsat and Death 1 C New Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Branche Ponenies Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Septimia SIP. Abdinose

1€Inpatient 2□ER/Outpetient 3□ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

23b. Did tobacco use contributa to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of ceuse of deeth?

1 Yes 2 No

1 P Yes 2□ No

26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how Injury occurred

1 Yes 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) and manner as steted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29c. License number

29b. Signature and title of certifier

5 Pending Investigation

6 Could not be determined

29d. Date signed (Month, Day, Year)

D25640

February 27, 1999

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

Hospital:

28a. Date of Injury (Month, Day Year)

Davachi M.D. 31. Date tiled (Month, Day, Year) 99

25. Wes case referred to medical examiner?

1 Yes 2 No 27. Menner of Death

2 Accident

3 Suicide

29a. Certifier

4 Homicide

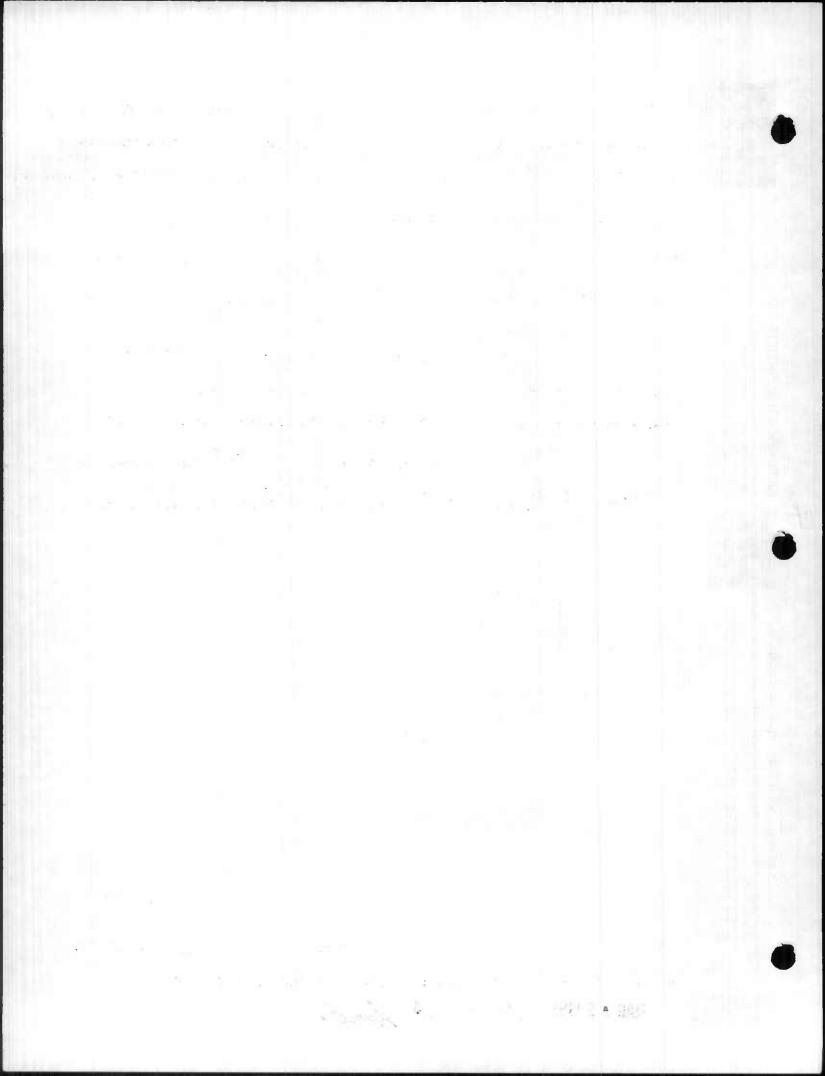
(Check only one)

1328 Southern Ave., Washington, D.C.

Registrar

2. Registrar's Signature





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Name (First, Middle, Last) 2. Dete of Deeth Month 730 March 4e Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington H Under 24 Hrs. 8. Deta of Birth (Month, Day, Year) 15 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Days Months Maryland 1 M 2 F 83 Yrs. 215-14-1590 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Washington Smithsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22240 Jefferson Blud. 21783 U.S.A. 14. Rece - American Indien, Black, White, etc. 11. Merital Status 12. Wes Decedent Evar In U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 XYes 2 No If Yes, Give Year or Dates: 41 - 46 1 Never Married 2 Married 1 Yas 2 No Specify: 3 XWidowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manufactured Welder 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Bessie Hartle Elvin Funk 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Coda) Stephen R. Funk (Son) 22240 Jefferson Blvd. Smithsburg, Md. 21783 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Steta 1 8 Burial 2 Crametion 3 Removal from State Beaver Creek Cemetery March6, 1999 Beaver Creek, Md. Signature of Funeral Sensice Lifens 22. Nama and Addrass of Facility 12525 Bradbury Ave. Davis Funeral Home lennes & Smithsburg, Md. 21783 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, ahock, or heart failure. List only one causa on each line. Approximate Interval Batween Onset and Death Immediate Cause (Final neumenia 2-22-99 disease or condition resulting in death) Dua to (or as a consequence of) TO Sequantielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical examiner? 26. Place of Deeth (Check only ona)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Md.

Funeral

Director

28a-f show

*natural", or items 23s or

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If them 27 is marked other than "n any Injury or other traumatic event, are less once.

death v

72 hours efter

Baltimore, Maryland 21215-0020

Funeral Director

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Completed

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1 Yes 2 No

29b. Signature and title of certified

Canton

Physician/Medical Examiner Completed by Be Medical Certification: To within 24 hours after death. To the Funeral Director: A

Division of Vital Records,

Hospital or Attending Physician:

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art II. Other:	significant co	onditions cont	irlbuting to dea	th but not resul	ting in tha unde	orlying cause
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- /	1/11/	Turn	laut	- 111	nent	10
	1000	my	- MACUL		10.00	-

2 ER/Outpatient 3	DOA Other	4 Nursing Home	5 Residence	8 Other (Specify)
	1			

1 Inpatient 28a. Dete of Injury (Month, Dey Year) 27. Manney of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accidant

6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Pleca of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 ☐ Homloida

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Hospital:

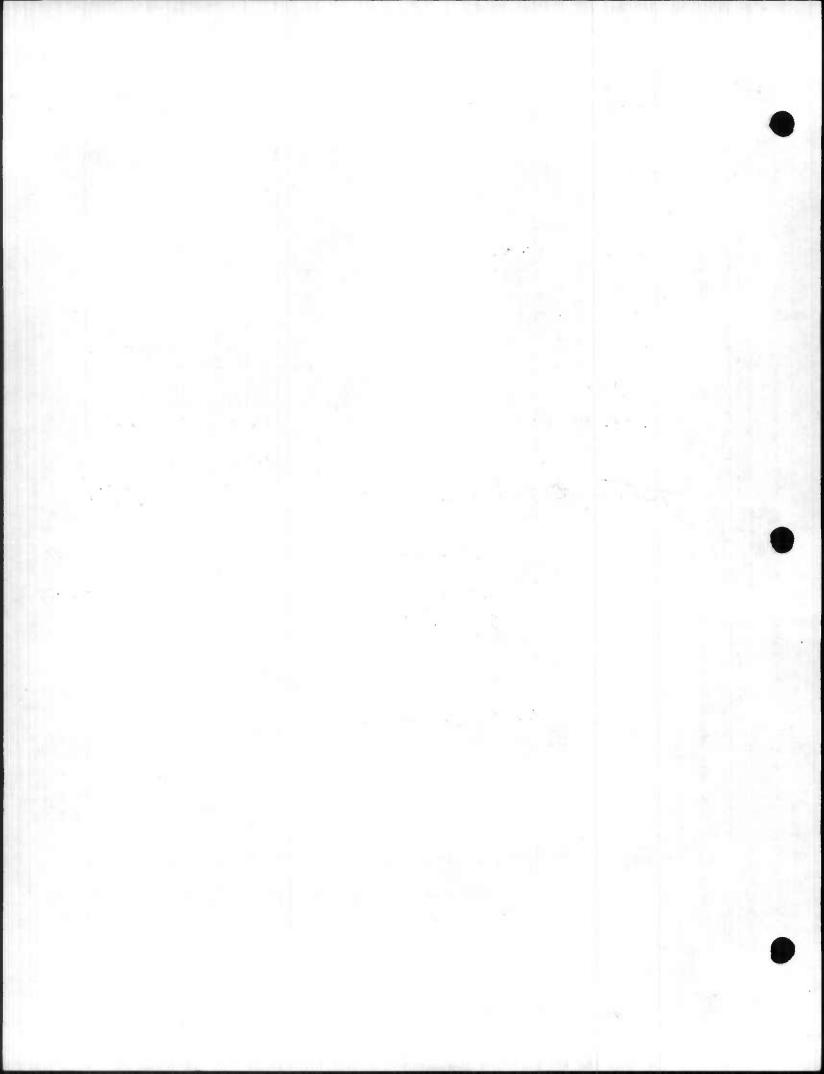
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Data signed (Month, Day, Year)

State Registrar 31. Dete filed (Month, Dey, Year) MAR 0 4 1999

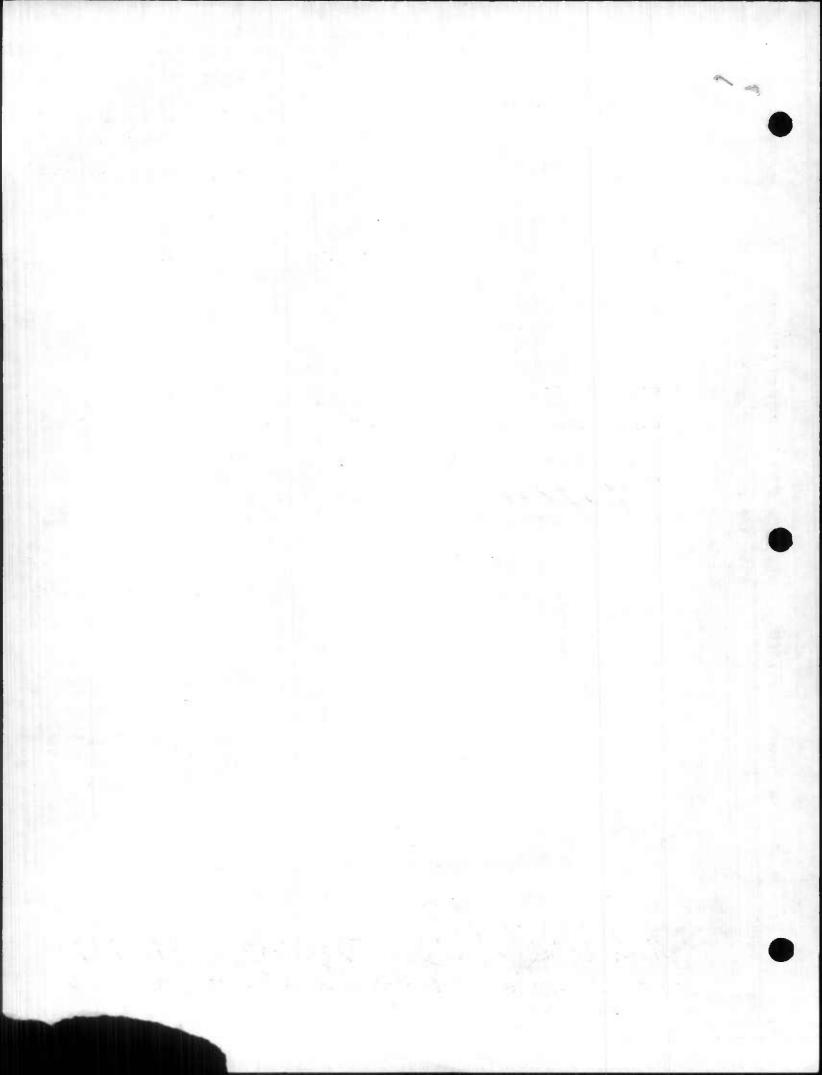
2291 32. Registrer's Signature

29c. License number



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

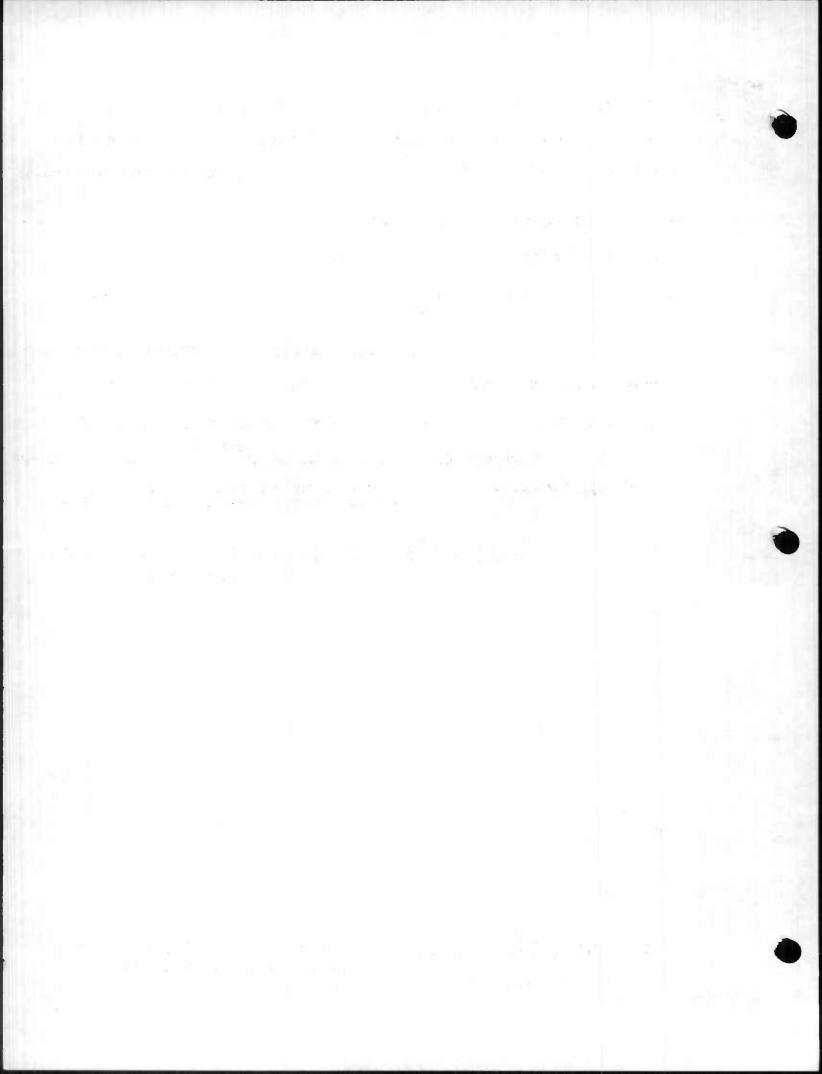
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Death Month Physician Scott Evan FAZENBAKER march /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Washington County Hospital Hagerstown Washington if Under 24 Hrs. Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthdey) If Under 1 Year 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Deys 1 ☑ M 2 ☐ F Months Yrs. Director 218-50-4799 Oct. 16 1951 W. Virginia Usual Residence of Deceden 10e Stete 10b. Counts 10c. City. Town or Location 10d. Inside City Limits must be notified N☐ Yes 2☐ No Directo 288-1 Maryland Washington Hagerstown 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Nerns 23s or 17229 W. Washington Street 21740 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 ☐ Married 1 Yes 2♥ No Specify: natural, or Baltimore, Maryland 21215-0020 þ 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) None None and Mental Hygie is marked other 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be Edward A. Fazenbaker Carole Cooper 19e. interment's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracey Mozingo - Daughter If Ibam 27 124 E. First Street Hagerstown, Md. 21740 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 8 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel trom State 4 ☐ Donation 5 ☐ Other (Specify) 3/10/99 Hagerstown, Maryland Hagerstown Crematory 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 red Li Vistel 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate intervel Between Onset and Death **Physician** /Medical Immediete Cause (Finel diseese or condition resulting in deeth) Examiner Examiner physician and s the burial-trans Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es e consequence ot): 23b. Did tobacco use contribute to the cause of death? P.O. Pert tl. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 1 Yes 2 No à 3 Probably 4 Unknown signed l Records, p 24b. Were autopsy tindings available prior to 24a. Wes an autopsy performed? Completed completion of cause of death? page 2 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Wes case referred to medicel examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 1 Inpatient this 28a. Dete of Injury (Month, Day Year) funeral 27. Menner of Deeth 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred Certification: Attending 1 Netural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. n 24 hours after death we Funeral Director: A pletaty filled in by tha f 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 8 Hospital Certifying Physician: To the best of physicians to the best of physicians to the course of the course of the course of the basis of physicians and place and place and due to the cause(s) and due to the ceuse(s) and due to the ceuse(s) and due to the ceuse(s) 29a. Certifier Medical (Check only To the To the To the 29b. Signifiure and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0 23a) (Type, Print) 1110 GALLA W MAKTIN EDICA, EXSTOWN 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State MAR 11 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1. Decedent's Neme (First, Middle, Las	st)					2. Dete of De		3. Time of De
Physicia /Modie	_	ROBERT F	RANCIS	FAY				Month C	H 09	1999 8:207
/Medic	_	4e. Fecllity Neme (If not institution, give	e street end number)			4	b. City, Town, or	Location of Deet	h 4c. County	
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Funerai Director		5. Sociel Security Number 033-20-0228 1 Usuel Rasidence of Decedent	ex M 2□ F	e (In yrs. lest bir 70	Yrs. If Und Month	der 1 Year ns Deys	If Under 24 Hr. Hours Mir	8. Date of Bi (Month, Do Septemb	er 2,192	9. Birthplace (State or Fi Country) 28 Massachuse
show		10a. State 10b. County		10c. City, Tow	n or Location					10d. Inside City L
28a-f sho	ţō	Maryland Washin	aton	Hager	stown					1 ☐ Yes 2
r 28a-f	9	10e. Street end Number	3			Zip Code			10g. Citizen of V	Whet Country?
23a or		17908 Sand Wedge	Drive			2174	10		U.S.	Α
or items		11. Maritel Status 1 Never Married 2 Married 3 Vidowed 4 Divorced	12, Was Decedent I Armed Forces? 1 Wes 2 N If Yes, Give Yeer or Deles:	1946-	13. Wes Decedent of Hispenic Origin? (If Yes, specify Cuben, Mexican, Puer 1 ☐ Yes 2 ☒ No Specify:		(Specify Yes or No- erto Ricen, etc.)		Rece - American Indian, Bleck, White, etc.	
"natural",	eted	15. Decedent's Ed (Specify only highest gra		1966 16e.	Decedent's Us (Give kind of	lent's Usuel Occupation kind of work done during most of working DO NOT use retired)		orking	16b. Kind of Bu	usiness/industry
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othe vent	Be	17. Fether's Neme (First, Middle, Last)					18. Mothar's Na	ma (First, Middle	, Meiden Sumen	ne)
Mental Brked o	ToB	Frank Patri	ck Fay				Mario	n Du	ncan	Laird
and N		19a. Informent's Name/Relationship (7	19b	. Mailing Addre	ess (Street	end Number or F	lural Route Numb	er, City or Town,	State, Zip Code)	
8 8 8	Delores Y. Ro	se	77	7 South	n Fede	eral Hio	hwav. Po	mpano Be	each, F1. 33	
Department of Health Important: If Item 27 i eny Injury or other tr. once.		20e. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 ☑ Other (Specify	Removel from State Discontinuous Entombmer	20b. Piece of	Disposition (A	Verne of		O Pete	20c. Location -	City or Town, State
Department of Important: If It leads Injury or once.		21. Signeture of Funeral Servica Lican			22. Neme	end Addres	ss of Fecility		L Home,	
		70.7000							Hagerst	own, Md. 217
ysician Medical		shock, or heart feilure. List only of Immediate Cause (Final	one ceuse on each lin	10.	not entar the m	oda of dyln	g, such as cardie	oc or respiratory e	errest,	Approximete Intervel Batwee Onsel end Dee
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Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 6-15 AM Raymond Edward Foltz march 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington Hagerstown Washington County Hospital If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, Year) Sept. 10, 1917 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days Months Virginia Yrs. 81 209-10-3579 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1√ Yes 2 No Hagerstown Maryland Washington 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 USA 501 Claire Street 12. Was Decedent Ever in U,S. Armed Forces? 1 Å Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 14. Race - American Indian Bleck, White, etc. 1 Never Married 2X Married Specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Inspector Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Mary Belle May Ernest Newton Foltz 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17510 Virginia Avenue Hagerstown, Maryland 21740 Ray E. Foltz/Son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Special Cedar Lawn Memorial Park 3-10-99 Hagerstown, Maryland 5 Other (Spec 21. Signature of Funeral Services 22. Name end Address of Facility
USDOTNE FUNETAL HOME 425 S. Conococheague St.Williamsport, Maryland Enter the visues, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear millure. List only one cause on each line. Approximete Intervat Between Onset and Death Immediete Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last with Pleural Efforcion give Heart Disease Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? Actació verrais Malfornation 1 Yes 2 No 1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ir than "netural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at

Hygiana.

permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygian important; if flom 27 is marked other that any injury or other traumests.

Baitimore, Maryland 21215-0020

Directo

P

Completed

Be

Examiner Physician/Medical þ Completed Be 10

25. Was case referred to medical examiner? 1 Yes 22 No

Certification:

edicai

State

Registrar

this The Hospital or Attending Phone 24 hours after death.

Funeral Director: After the plately filled in by the funaral To the Hosp within 24 ho To the Fune complataly fi

Division of Vitai

27. Manner of Death

29a. Cartifier (Check only one)

1 Natural 2 Accident

3 Suicide

4 Homicide

5 Pending investigation 6 ☐ Could not be

Hospital: 1 Anpatient 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

🗠 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner es stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier

10 Vaden (n)

29d. Date signed (Month, Dey, Year)

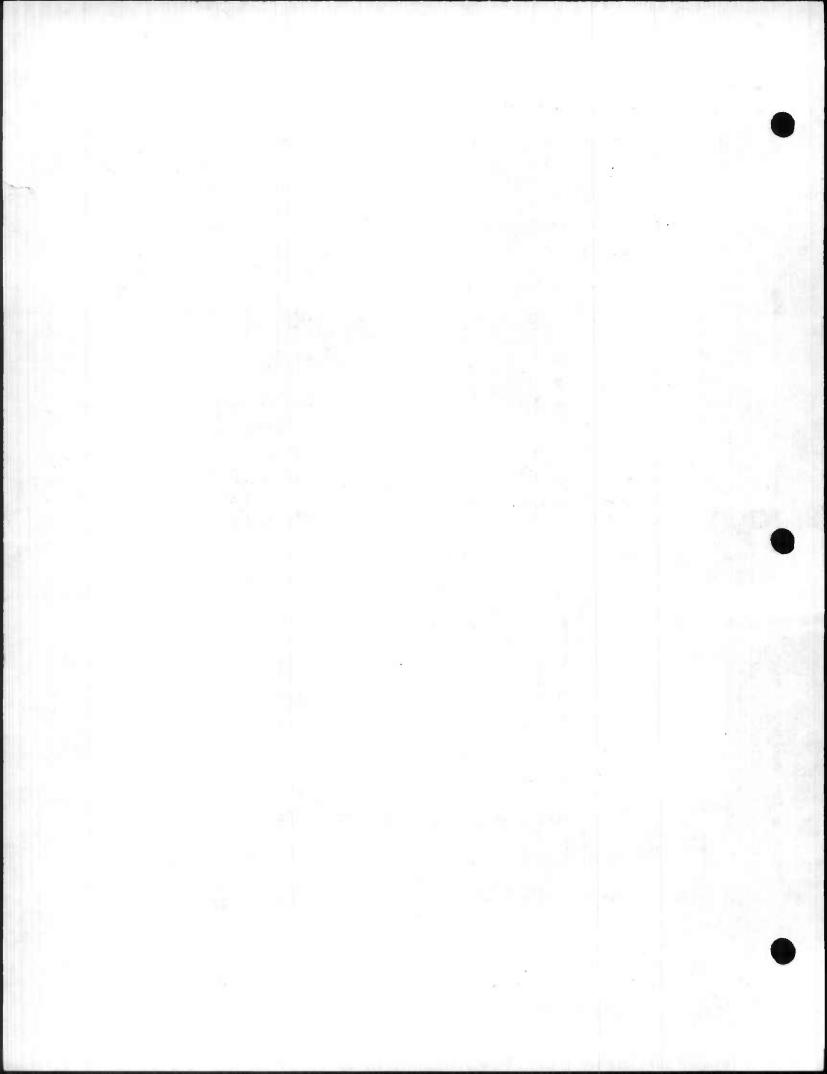
30. Name and eddress of person who completed cause of death (ttem 23a) (Type, Print)

TANVIR A. PASHA MD 376 MILL ST.

31. Date filed (Month, Day, Year) MAR Q 9 1999

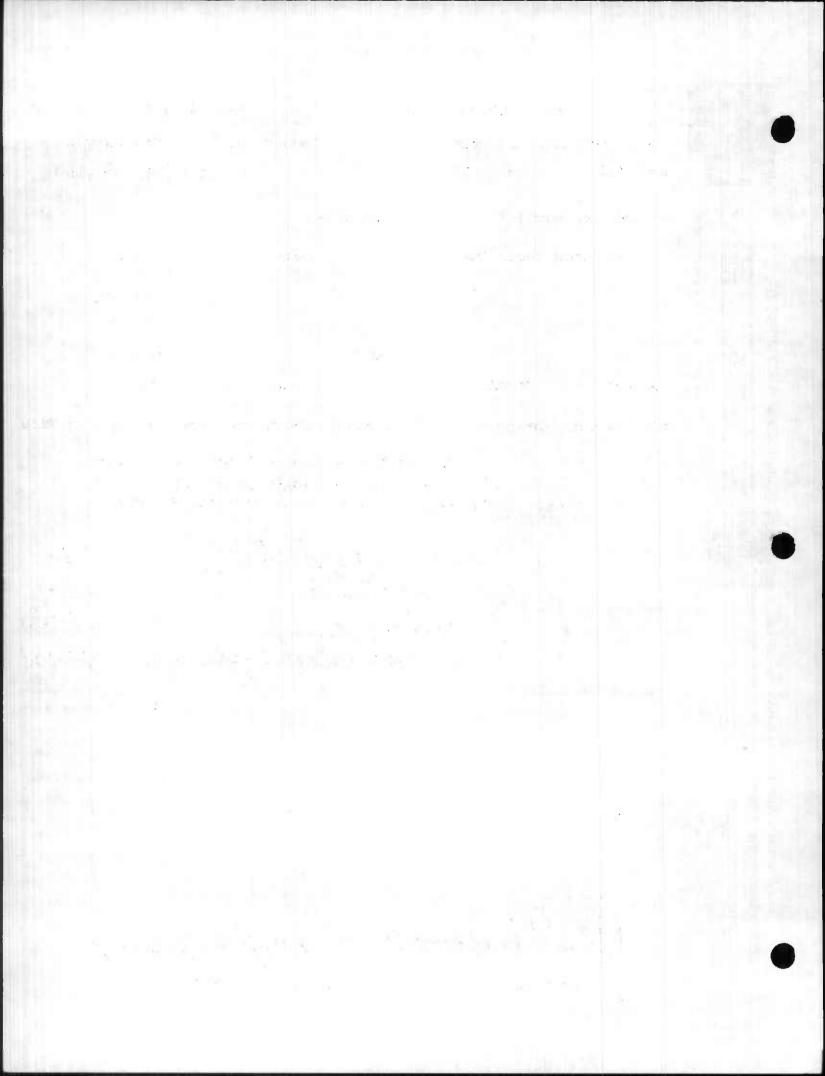
32. Registrar's Signature

HAGERSTOWN MAZI 740



Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legible.

	State of Maryland / Department of Health Certificate of Deat 1. Decedent's Name (First, Middle, Last)	
Physician /Medical	Ruth Elfleeta Graves	March 4, 1999 2:50 AM
Examiner Funeral Director	St. Mary's Nursing Center Leon	Town, or Location of Death Ac. County of Death Ac. County of Death St. Mary's Mary's 9. Birthpleca (Stata or Foraign (Month, Day, Year) September 4, 1910 Maryland
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Insida City Limits
28a-f ahow notified at	Maryland St. Mary's Mechanicsville	1 ☐ Yes 2 🖔 No
than 'natural', or items 23a or the Medical Examiner must be ompleted by Funeral Di	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
	New Market Turner Road 2065	59 U.S.A.
	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Worldowad 4 Divorced 12. Was Dacedant Ever in U,S. Armed Forces? 1 Yes 2 No It Yes, Give Yaar or Datas:	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Light Secondary (1-12) College (1-4or 5+) Light Secondary (1-12) College (1-4or 5+)	
	9th Homemaker 17. Fathar's Nama (First, Middle, Last) 18. Mo	Own Home ther's Name (First, Middle, Maiden Surnama)
		nnie Irene Goodling
_	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num	mber or Rural Route Number, City or Town, State, Zip Code)
mportant: If item 27 is marked other iny injury or other traumatic event, 20GB. To Be C	Ruth Graves Hill/Daughter 20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from Stete 4 Donation 5 Other (Specify) 26818 Baptist Chu 20b. Place of Disposition (Name of cemetery, cramatory or other place) Trinity Memorial Gard	dens 3/8/99 Waldorf, MD
cian ical iner		Leonardtown, MD 20650 as cardiac or respiratory arrest. Approximete Interval Between Onset and Deeth
ian/Medical Examiner	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last	Insufficiency years
Completed by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Pa	art I. 23b. Did tobacco use contribute/o the cause of death
npleted by Pl		24e. Was an autopsy performed? 24b. Were eutopsy findings available prior to completion of causa of death?
rector, page 2		1 Yes 2 XNo 1 Yes 2 No
To Be	exeminer? Hospital:	ece of Death (Check only one) [Nursing Home 5 Residence 8 Other (Specify)
completely filled in by the funeral di	27. Manner of Deeth 1 XNatural 5 Pending investigation 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 28b. Time of Injury M 1 Yes 2 28c. Injury et Work? 1 Yes 2 28c. Injury et Work? 1 Yes 2	28d. Describe how Injury occurred
pletely filled edical Ce	29a. Certifier (Check only only only only only only only only	
nd mos	290. Signature and title of certifier 290. Licensa number D 06	29d. Data signed (Month, Day, Year) 3-4-99
		ood, MD 20636
State Registrar	MAR 0 4 1999 32. Registrar's Signeture MAR 0 4 1999	

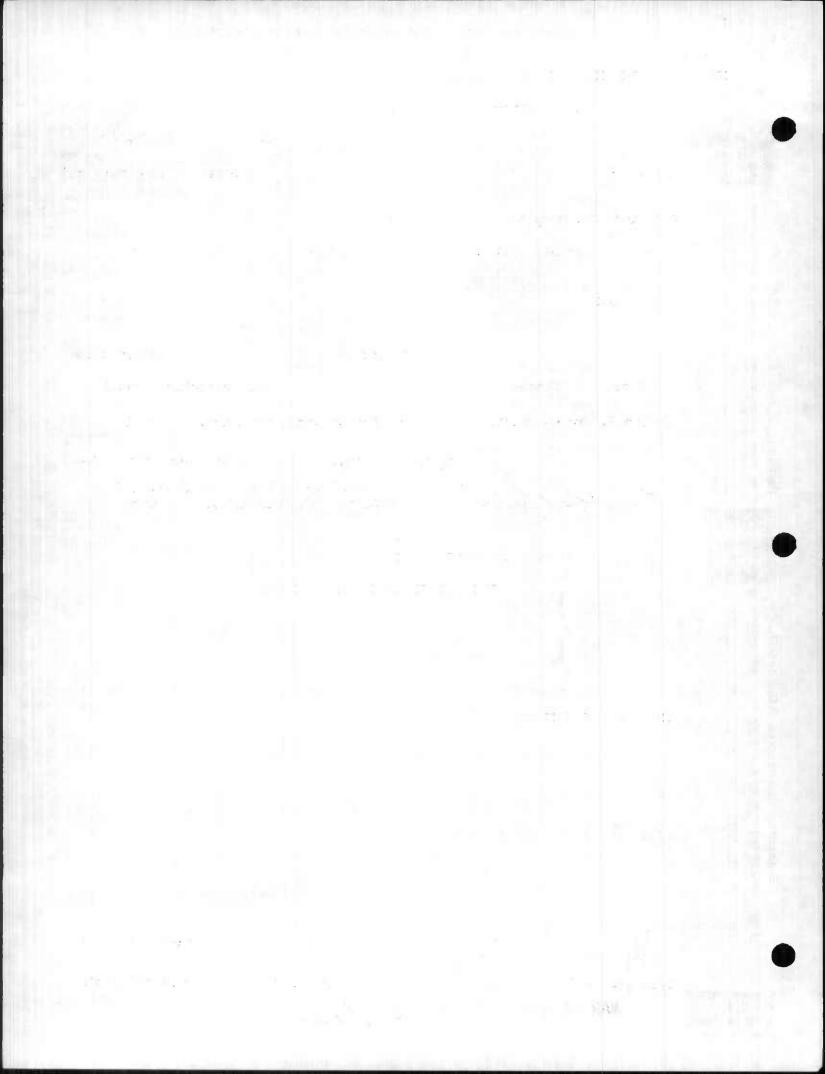


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Jo

	: #23 PART I, II, 27 P 1. Decedent's Neme (First, Middla, L	ER MEO G769 3-22 ast)	-99 WR.Ce	rtificate of	Death	2	2. Deta of Deet Month	eg. No.	Year	3. Tima of Deeth
Physician /Medical	Joseph	Francis G	aves Sr				March (199		10:00 A.N
Examiner	4a Facility Nama (If not institution, g						ation of Death	4c. County		
74	42202 Greenwell			If Under 1 Yea	Leona:			St. M	7 -	
Funeral Director	5. Social Security Number 6. 214-42-6656 Usual Residence of Decedent	Sex 1 XM 2 F 7. Age (In	yrs. last birthday 54 Yrs.	Months Day		Min.	B. Dete of Birth (Month, Day, February			ace (State or Foreign try) 1 land
72 hours after death with the Maryland natural; or itams 23s or 28s-f show and Examine must be not set at	10e. State 10b. County		City, Town or L						10	od. Înside City Limits 1 ☐ Yes 2 No
flar death with the flame 23e or 2 when ment be an Funeral Direction of the flame and							10g.			
flar death verified the same same same same same same same sam	11. Meritel Status	12. Was Decedant Evar	12. Was Decedant Evar In U.S. 13. Was Decedent of Hispa			ain? (Speci	ify Yes or No-		S.A.	
urs after of iter	3 ☐ Widowad 4 🗓 Divorced	Armed Forces? 1 ☐ Yes 2 Z No If Yes, Giva Yeer or Dates:		If Yas, specify Cu 1 ☐ Yes 2 ☐XN	ben, Mexicen	i, Puerto Ri	ican, etc.)	Specify	k, White, e	nite
ed within 72 hours ygiene. wr then "natural", rt, tre Medical Ex Completed by	15. Decedent's (Specify only highast g Elementary/Secondery (0-12)		16e. Dece (Give life.	edent's Usuel Occi a kind of work don DO NOT use retii	upetion e during most red)	t of working		16b. Kind of Bu	usiness/Ind	lustry
		Al	Ca	rpenter	10 Matho	rie Nome ((First, Middle, M		truct	ion
Saby W	17. Fathar's Nama (First, Middle, Last Alfred V. G	raves				lice		beth M		
12 should bh and Mente 7 Is merked traumetic a	19a, Informent's Name/Reletionship		19b. Meil	ing Address (Stree						Code)
d 2 d Thar Trau	Joseph F. Grave			12 Hurry				MD 2062		
ーゴミラ	20a. Method of Disposition	20	b. Plece of Disp	osition (Neme of ematory or other pi		- Crace		20c. Location -		wn, State
age t: # y or	1 ☐ Burial 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spec	□Removel from State ify) M		an Cremato		3/5	5/99 A	lexand	ria.	V/A
permit. Pages 1 a Department of Ha Important: if item any injury or othe	21. Signeture of Funeral Service Lice	ensee /) 2	2. Name and Add	ress of Facility	y diner	Funera	1 HOme	РΔ	
Physician /Medical	23a. Part1. Enter the disease, or conshock, or heart failur. List onl	mplicetions that caused by a yone cause on each lin	Matri. Do not er	P.O.Box iter the mode of dy	270, I.e.	enardiec or	dtown, respiretory arm	MD 206.	50	Approximete Intervel Between Onset and Death
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be axecuted sician and bunal-transit	Sequentially list conditions, if any, leeding to immadiate ceuse. Enter Underlying Ceuse (Disease or injury c.									
ate the	Ceuse (Diseese or injury that initiated avents rasulting in deeth) Lest	C. Dua ti	o (or as a consa	s a consaquanca of):						
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tha deay the a ached f hysic	Part il. Other significant conditions	contributing to death but not	resulting in the	underlying cause o	jiven In Pert I.		23b. Dld to	bacco use co	ntribute to	the cause of death?
	LIPOSARCOMA OF PERI	TONEUM					1 🗆 Yı	es 2 No	3 Prob	ably 4 Unknow
been should							24a. Wes e perform	n eutopsy ned?	ava	ore autopsy findings alleble prior to appletion of causa deeth?
sician: The law requiras t certificate has been signs irector, paga 2 should be-							1104	s 2 No		Yes 2□ No
certificate rector, pag	25. Was casa referred to medical				26. Place	of Deeth	(Check only on	e)		
2 00	exeminer? 11∕2 Yes 2 □ No	Hospitel:	2 ER/Outpetie	nt 3 DOA	ther.		The state of		er (Specify)
Attending Phar death. ector: After thi by the funeral	27. Manner of Deeth 1 🖾 Naturel 5 🗆 Pending 2 🗆 Accident Investigati		28b. Time (Injury		A Nursing Home 5 Presidence 6 Other (Specify) 3c. Injury et Work? 1 Yes 2 No					
tal or Attending P is after death. al Director: After led in by the funers Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homlcide determine	200. Piece of Injury - 7	28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Ro City or Town, Stata)					l Route Number,		
he Hospi in 24 hou he Funer plataly fil edical		hysician: To the best of my miner: On the besis of exan end menner stated.								
To the Within Company	29b. Signature end title of certifier	mickell		29c. Lice	O.C.M.	.E.		9d. Dete signe larch 03		
State	30. Name and address of person who MALYN (NS 31. Date filed (Mogth, Day, Year)	Completed cause of death (Uh 111	Penn St	reet, E	Bal.tir	more, M	laryland	1 212	01

Registrar



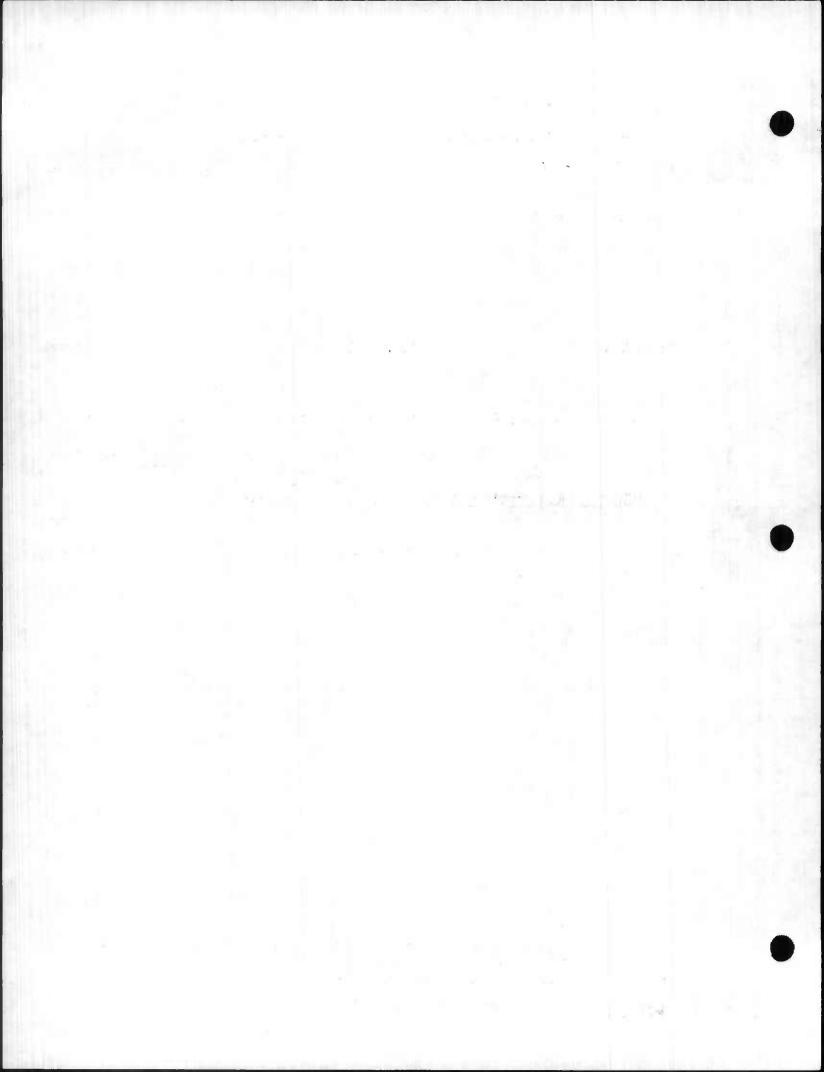
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Frederick A. Ginn, Jr. March 7, 1999 6:05am /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner VA MARYLAND HEALTH CARE SYSTEM PERRY POINT CECIL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Dey, Year) April 19 1926 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 10 M 20 F Months 72 214-20-9820 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours efter death with the Manyland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumstic event, the Mental Evergent must be notified as 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Directo Maryland Cecil Chesapeake City 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 705 Knights Corner Rd. 21915 USA Funerai 12. Was Decedent Ever In U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Black, White, etc. 1 Never Married 2 ☐ Married GINN, FREDERICK A. JR Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Brick Layer Masonary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick A. Ginn, Sr. Agnes M. Atwell 19a. tnforment's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Brown/Nephew PO Box 2 Chesapeake City. MD 21915 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) A. Ferris & Co., Inc. 3-9-99 West Chester, PA 22. Name and Address of Facility
R. T. Foard Funeral Home, P. A. 21. Signature of Funeral Service Licens Lea 318 George Street Chesapeake City, MD 21915 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Pneumonia 2 weeks **Examiner** Due to (or es e consequence of): Examiner Liver Disease/End Stage Cirrhosis l Year physician end es the bunal-transit that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Due to (or as e consequence of): NAME KNOWN TO PHYSICIAN: Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequenca of) 98 use for ed by tha e 23b. Did tobacco use contributa to the cause of death? Part II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yae 2 No 3 Probably ¾ Unknown à 24b. Were autopsy findings avaitable prior to completion of cause of death? 24a. Was an autopsy performed? Completed After this certificate has funeral director, page 2 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical axaminer? 26. Piece of Deeth (Check only one) Other: 4♥ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 ☐ Yes 2♥ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation after death Director: 6 Could not be determined 3 Sulcide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 24 hours 29a. Certifier 1 Cortifying Phyelcian: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end menner as stated. edicai completely (Check only 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number 3/7/99 ME0066318 Florida 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8+1 VA OMAR PEREZ, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD. 21902 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 9 1999 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** 1999 Albert L. Groff March 7:15 a.m /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 224 Conestoga Street Residence: Charlestown Cecil If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 175-28-3435 12 M 2□ F 97 Yrs. ,1901 Pennsylvania Director Usuel Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or flams 23a or 28a-f ahow adical Examiner must be notified at 1 Yes 2 No Director Maryland Cecil. Charlestown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 224 Conestoga Street 21914 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Haalth and Mental Hygiene. Important: if itam 27 ia marked other than "natural", or the any injury or other traumatic avent, the Med. 1 ☐ Yes 2 🗓 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: by White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Seven Years College (1-4or 5+) Self-Employed Electrician Electrical Business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edwin Groff 2 Marabella Hutton 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Schmidt (Daughter) 224 Conestoga Street, Charlestown, Maryland 21914 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1 Burial 2 □ Cremetion 3 □ Removal from State Calvary Cemetery 3/5/99 West Conshohocken, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility Lee A. Patterson & Son Funeral Home 21. Signat re of Funeral Service Licens Perryville, Maryland CHIEVADX 21903-0188 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete intervel Between Onset and Death **Physician** Immediete Cause (Final disease or condition resulting in deeth) /Medical MESOTHELIOMA 2 YEARS Examiner Due to (or es a consequence of): Examiner sician and buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or es e consequence of): Box 68760. Physician/Medical the Due to (or es e consequence of): 88 P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed by Completed by Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy 1 ☐ Yes ŽIXNo 1 ☐ Yes 2 ☐ No certificate of Vital or Attanding Physician: Be 25. Was cese referred to medicel 26. Place of Death (Check only one) Other: 4 Nursing Home Standardence 8 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA edicai Certification: To 1 Yes XX No this 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After Division 1 Natural 5 Pending after death. 1 Yes 2 No investigation 2 Accident 8 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide • Funeral L Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier compietaly (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. within 2 To the ş 29c. License number 29d. Date signed (Month. Day. Year) 29b. Signeture end title of certifier 0 Catronics 845344 30. Name and address of person who completed cause of deeth (ttem 23a) (Type, Print) 12 Suresh M. Dhanjani, M.D., 20 Graigtown Road, P.O. Box 781, Perryville, Maryland 21903 MAR 0 4 1999 32. Registrar's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

STANLEY

State of Maryland / Department of Health and Mental Hygiene ITEMS: #23 PART I, 27, 28A-F PER MEO G769 3-22 Certificate of Death **GROSS** 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2, 1999° Physician MARCH 12:30P.M. Stanley Harrison Gross, Jr. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner 710 CABIN BRANCH DRIVE SEAT PLEASENT PRINCE GEORGES If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Year) If Under 1 Year 5 Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. lest birthdev) **Funeral** Months 1₩ M 2□ F Days 54 Yrs. 578-58-3013 SEPT. 17, 1944 Hughesville, Md Director Usual Residence of Deceden Pagas 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mentel Hyglana.

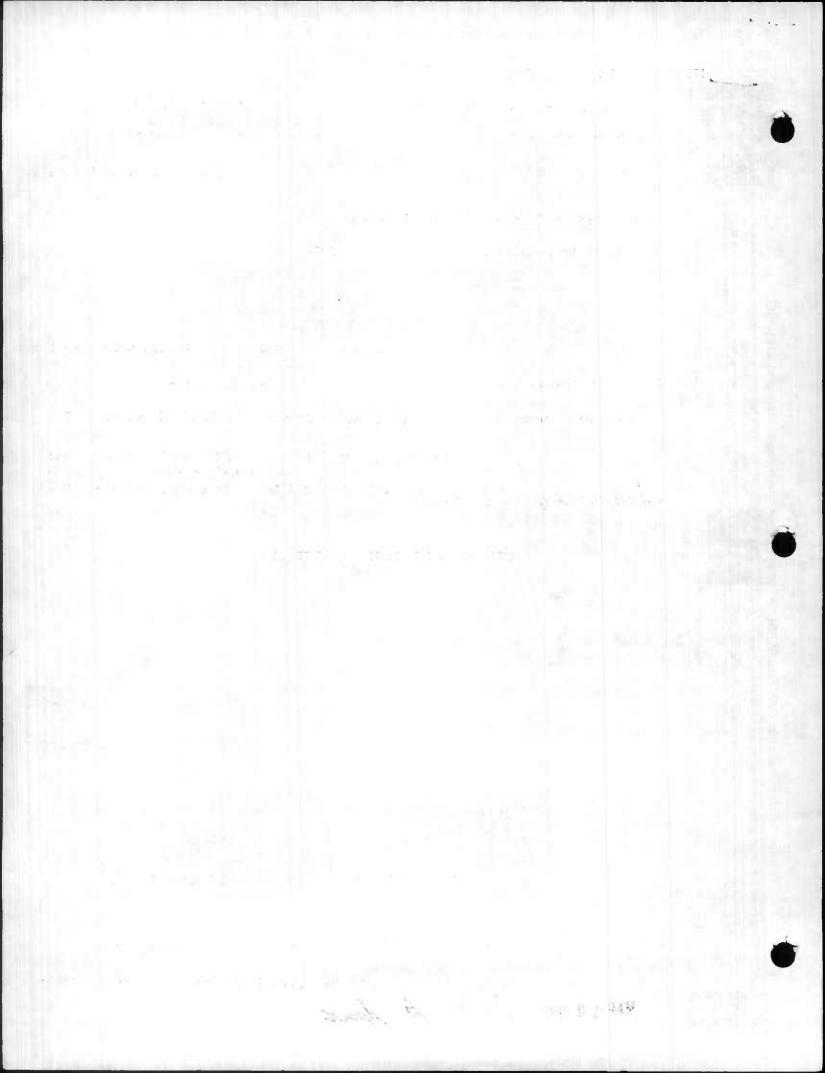
nent of Health and Mentel Hyglana.

nent: If item 27 is marked other than "netural", or items 23e or 28e-f show up or other transmit be notified at ury or other transmit be notified at 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 1 Tyes 2 □ No Maryland Prince George's Seat Pleasant Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 710 Cabin Branch Drive 20743 USA Funeral 14. Race - American Indian, 12, Wes Decedeni Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify. BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Pentagon Heating Plant Engineer (foreman) 12th 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Stanley H. Gross, Sr. Gladys T. Curtis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Charles Gross/ Brother 6011 Walton Avenue Suitland, Maryland 20746 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State permit. Paga Department o important: If i Harmony Memorial Park 3/9/99 Landover, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home of MD 21. Signature of Funeral Service Licenses Suitland, Maryland 20746 4308 Suitland Rd. 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximete Interval Between Onset and Deeth Physician immediate Ceuse (Final disease or condition resulting in death) /Medical ACUTE ALCOHOL INTOXICATION AND FATTY LIVER Examine Due to (or as a consequence of): Examiner physician and tha buriel-frensit that the death certificeta be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of) 89 attending for usa as signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eulopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? cartificata hes b 1 Yes 2 No 1 ☐ Yes 2 ☐ No director. Attending Physician: Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To funaral 28a. Dete of Injury (Month, Dey Year) 27, Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred P Affar 1 Netural 5 Pending UNKNOWN 1 Yes 2 No death. investigation Found: 3-2-99 Found: 12: M5 2 Accident aftar daati Director: 6 X Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 710 CABIN BRANCH DRIVE 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 124 hours aftar re Funeral Direction of Filled in the 4 Homicide 8 FOUND: RESIDENCE SEAT PLEASANT, MAYLAND 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) end menner as stated.

**Afficient Physicien: To the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical To the Hosp within 24 hor To the Fune complately fi (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie MARCH 3, 1999 O.C.M.E. 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) KOMER RYBRITS Wy 111 Penn Street, Baltimore, Maryland 21201 AR 1 0 1990

32 Registrar's Signeture

State Registrar



or Attending Physician: The law requires that the death certificate be asscuted Division of Vital Records, page 2 should be Be Completed certificate edical Certification: To this After To the Mospital or Attanding within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun

1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** Clara Gilbert February 19, 1999 /Medical 4e Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Center Clinton Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1□M 2X F Yrs. Director May 27, 1917 <u>215-52-6268</u> UNKNOWN Usual Residence of Decedent 10a. State 10c. City, Town or Location ns 23s or 28s-f show Director Md. Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20744 Funeral 12604 Prestwick Drive U.S.A. pernit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic avent, the Medical Examination. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Unknown UNKNO UN Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Unknown Unknown 19e. Informent's Neme/Reletionship (Type, Print) MRDDA 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 429 Michele Wallace Case Manager 0 Street N.W. Washington, D.C. 20001 20b. Plece of Disposition (Name of 20c. Location - City or Town, Stete 20e Method of Disposition FOREST HILLS CLINTON MARYLAND 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 Donation 5 ☐ Other (Specify) 2/26/99 22. Name and Address of Fecility W.H. Bacon Funeral Home 21. Signature of Funeral Servica Licenses 887 3447 14th St. N.W. Washington, D.C. 20010 Dacon anda 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. **Physician** CONGESTIVE HEART FAILURE /Medical Immediete Ceuse (Final disease or condition resulting in deeth) **Examiner** Due to (or es a consequence of): MITRAL REGURGITATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760, Physician/Medical Due to (or es a consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. TRICUSPID REGURGITATION þ

3 YRS. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Wes an autopsy

ATRIAL PIBRILL ATTON

24b. Were autopsy findings available prior to completion of cause of death?

21

3. Time of Death

11:40p.m.

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximete tntervel Between Onset end Death

1 ☐ Yes 2 ☐ No

1 XYes 2 □ No

2 No 1 Yes

25. Wes case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ★Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, term, street, tectory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier

1 Sertifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture end the of certifier 29c. License number

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

8926 Woodyard Rd. Clinton Md. 20735

State Registrar 31. Dete filed (Month, Day, Year) FEB 2 3 1999

Nelson Benjers

32. Registrer's Signeture sparke

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State of Maryland / Department of Health and Mental Hygiene 9 0877

					Cert	ificate	e of i	Death		Reg. N	0.	00	1 1	I
		I. Decedent's Neme (First, Middle, La	st)						2. Data of I	Death		Yaar		of Deeth
Physicia: /Medica	_	Anne	E. Go.	lladay	У				March	2,	1999	1 001	11:4	5 A.M
Examine	100	la Facility Name (If not Institution, give)			4	b. City, Town, or		-	c. County			
VI.		2343 Iverson St	reet					Temple				Geor	0	
Funeral Director		5. Social Sacurity Number 6. Sax 7. Age (In yrs. lest birthdey) 1 M 2XXX 82 Yrs. Months Days Hours Min.											or Foreign	
tand tand	-	10a. State 10b. County		10c. City	y, Town or Loca	ation						10	d. Insida	City Limits
sth with the Merylar 23s or 26s-f show	5	Maryland Prince (George's	Te	emple H	ills				1 ☐ Yas 2 🕅 No				
r 28a	Director	I Oe. Street and Number		1		10f. Zip	Coda			10g. Citizen of What Country?				
3a o		2343 Iverson Stre	oot			21	0748			ı	J.S.A			
items 2	Funeral	11. Marital Status			lispanic Orlgin? (an, Mexican, Pue	Specify Yes or I		14. Race	e - Amarice					
urs a	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	(No		Yes :		Specify:	no ricen, etc.)			k, White, e Whit		
d within 72 hours all giena. In then "natural", or	Completed	15. Decedent's Ed (Specify only highest gre			16a. Decede	nt's Usua	I Occup	ation	ndelna	16b.	Kind of Bu	siness/Ind	ustry	
5 .	e -	Elementary/Secondary (0-12)		College (1-4or 5+)			(Give kind of work done during most of wo life. DO NOT use retired)							
filed withi Hygiena. rther than	5	12			Recep	tion	ist				lote1			
al Hyginal Action	Be	17. Father's Name (First, Middle, Last)	18. Mother's Ne			n Sumam	10)							
should be nd Mental marked o	2	Charles Franklin	Plauger						May Mun					
d 2 should be file th and Mental Hy ? Is marked oth traumatic event		19a. Informant's Name/Relationship (* .					and Number or F					Code)	
and salth m 27		Wilma Clem/Daught	er	lest 5				Ct. Wh						
10 10	2	20a. Method of Disposition 1 Disposition 2 Cremation 3 Disposition	Removal from State		lace of Disposi ametary, creme	etory or o	ther plea	ce)	Dele	20c. 1	Location -	City or Tov	wn, State	
Pa ment: jury		4 Donation 5 Other (Specific			surrect				3/6/99	Clir	nton,	Mary	land	
epar report ny in	1	21. Signalure of Funerat Servica Licer	see / /					ss of Facility Kalas F	uneral	Home	P A	1		
20289		Hearyage	. dalas					Hill Rd					5	
A 845		23a. Part1. Enter the disease, or com- shock, or heart tribure. List only	plications that cause	ed the death	n. Do not enter	the mod	e of dyir	ng, such as cardia	ac or respiratory	arrest,	,		Approxim Interval B	ete Setween
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Co	Due to lo	r es a consequ	ence of):	Y	erst	fri	10	12		Onset an	d Death
D =	in in													
	Examiner	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury		Due to (o	o (or es a consequence of):									
100 PM 400	og	Cause Disease or Injury that initiated events resulting in death) Last	c	Due to (or	r as a consaque	ence of):						9		
eath cert attendin for use	Physician/M		d									-		
the death cery y the attendir ached for use	SIC	Part II. Other significant conditions of	ontributing to death	ibuting to death but not resulting In the underlyIng causa given in Part I.						23b. Did tobacco use contribute to the cause			e of death?	
at the de d by the e etached	Phy								1	☐ Yss	2□ No	3 Prob	sably 4	Unknown
as that igned t	ò								-			1		
	Completed								24a. W	as an eut rformed?	opsy	ava	ere autops ailable prid mpletion o death?	sy findings or to of cause
m - D	E								11	Yes	2 XNo	10	Yes 2	□ No
certificate		25. Was case referred to medical						26. Place of De	eath (Check on		11			
P	0	examiner? 1 X Yes 2 □ No	Hospital:	ient 2 🗆	ER/Outpatient	3□ DC	A Oth		Home 5XXA		6 Oth	ar (Specify	()	
a Physical Revenue of the series of the seri	ü	27. Manner of Death	28a. Date of In (Month, D		28b. Time of Injury		8c. Inju		28d. Describ			-		
l or Attending is after death. Director: After d in by the funer	atio	1 Neturat 5 ☐ Pending 2 ☐ Accident investigation		oy 1001)	nijury	М		Yes 2 No						
To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A pomplessity filled in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)								n (Street Town, Ste		er or Rura	l Route N	um <i>ber</i> ,
Hospital or 24 hours afte Funeral Dir letaly illied in	_		ysician: To the bes niner: On the basis and mannar s	of examinal										e(s)
within 2		295, Signature and title of certifier	1			290	. Licans	sa number		29d. E	Date signe	d (Month, I	Dey, Year)
1		1/2×	7/1	-			0	3969)		3/	3/9	9	
(no		30. Name and address of person who	completed cause of	death /Item	1 23e) (Type D	rint)			,		- 1	, ()	
(2)	,	Barry Redjae					Ave.	#201, T	emple H	ills	, MD2	20748		
State	۵ :	31. Date filed (Month, Day, Year)	1	trar's Signa										
- State		MAK 0 4 1999	Column	MA	A		- 4							

DHMH 16 Rsv 6/95

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State of Maryland / Department of Health and Mental Hygiene 🔍 🔾 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Yaar **Physician** Robert Everett Giddens 5:00 pm February 28, 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death **Examiner** 6808 Elbrook Road Prince George's Lanham If Undar 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foraign Country) 7. Age (in yrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 □ F Yrs 70 Aug. 15, 1928 Washington, DC 215-26-3393 Director Usual Residence of Decedent pemit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Haaith end Mantal Hygiene. Important: if item 27 is marked other than "naturel", or itema 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified an once. 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No Yes 2 No Prince George's Maryland Lanham Direct 10f. Zip Coda 10g. Citizen of What Country? 10e. Street and Number 6808 Elbrook Road 20706 U.S.A. Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ∰ Yas 2 □ No If Yas, Give Yaar or Dates: 1951-53 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, atc.) 11. Marital Status Black, Whita, atc. 1 Naver Married 2 X Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify by 3 ☐ Widowed 4 ☐ Divorcad White Completed 16a. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grade completed) Elamantary/Secondary (0-12) College (1-4or 5+) CTA Compositor 18. Mothar's Name (First, Middle, Maidan Sumame) 17. Father's Name (First, Middle, Last) George Giddens Naomi Groome 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant'a Name/Relationship (Type, Print) Betty B. Giddens - Wife 6808 Elbrook Road, Lanham, Maryland 20706 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) 03/03/99 Brentwood, Maryland Fort Lincoln Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Gasch's Funeral Home, P.A. tla nac 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Batwaen Onsat and Death **Physician** Immediate Cause (Final disease or condition resulting in daath) /Medical 4 WEEKS RESPIRATORY INSUFFICIENCY **Examiner** Due to (or as a consequenca of): Examiner 6 MONTHS CANCER OF THE LUNG the death certificets be executed physician and s tha bunal-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or injury that Initiated events resulting in death) Last Due to (or as a consequanca of): Division of Vital Records, P.O. Box 68760, Physician/Medical I Dua to (or as a consequenca of): 98 USB for signed by the a d be dateched f 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 N Unknown þ 24b. Were autopsy findings available prior to complation of cause of death? been signal eted 24a. Was an autopsy Compi has cartificete had 1 Yes 2 No 1 Yas 2 No Physician: Be 25. Was case referred to medical 28. Place of Death (Check only one) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 2 1 Yes 2 No this 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: or Attending Aftar 5 Panding Invastigation 1 Natural 1 ☐ Yes 2 ☐ No daath. Director: / 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, streat, factory, office building, etc. (Specify) efter 4 ☐ Homicide To the Funeral Di 29a. Certifian 🖒 Certifying Physician: To tha best of my knowledga, daath occurrad at the time, date and place, and dua to tha causa(s) and manner as stated edicai 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, data end place, and due to the causa(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier 29c. License number D. Weltzn 57550 March 1, 1999 30. Name and address of person who completed causa of daath (Item 23a) (Type, Print) Martin Weltz, M.D., 7525 Greenway Center Drive, Suite #205, Greenbelt, MD

22. Registrar's Signatura

DHMH 16 Rev 6/95

State

Registrar

31. Data filad (Month, Day, Year

MAR 0 2 1999

State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death FEBRUARY Arthur L. Green 5:00 AM 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Doctors Community Hospital Prince Georges Lanham If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 110 M 2□ F Deys Hours 59 Yrs. October 18,1939 Arkansas 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Prince Georges Lanham 10f. Zip Code 10g. Citizen of Whet Country? 8502 Nightingale Drive 20706 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Bieck, White, etc. 1 ☐ Never Merried 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify 3 Widowed 4 Divorced **Black** 15. Decedent's Education 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Analyst Computer Science 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) George W. Green Lorine Holmes 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Corine Green-Wife 8502 Nightingale Drive, Lanham, Maryland 20706 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 1 ☑ Buriai 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Fort Lincoln Cemetery 3-1-99 Brentwood, Maryland 21. Signature of Wheral Service Licen 22. Name end Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, Maryland 20722 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth CARDIAC Due to (or es e consequence of): myo curson MAKEGRON Due to (or es e consequence of): ARREPORTO LEVEN CARPIDIA SELLAM Due to (or es e consequenca of): Grad. PHIBLIEDS IN Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? UN FORTION 1 Yes 2 1100 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. injury et Work? 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State)

Examiner P.O. Box 68760, Division of Vital

Examiner burial-fransit The law requires that the death certificete be executed pue Physician/Medical the 88 use is certificate has been signed by the a director, page 2 should be dateched for ð Be Completed Certification: To this funeral After

Physician

/Medical

Examiner

Funeral

Director

must be notified at

the Medical Examinar

permit. Pages 1 and 2 should be film.
Department of Health and Mental Hygi
any injury or other

Physician

/Medical

Director

Funeral

Completed by

Be

5. Sociel Security Number

225-52-3383

10e. State

Maryland

10e. Street end Number

20e. Method of Disposition

immediate Ceuse (Final diseese or condition resulting in death)

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest

1 Yes 2 No

27. Menner of Death

2 Accident

3 Suicide

29a. Certifier

4 - Homicide

(Check only one)

29b. Signature end title of certifier

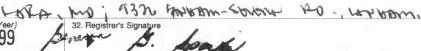
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Records, or Attending Physician: efter death. in by the Pelli • Funeral C Hospital pmpletely To the within 2

State Registrar

Medical

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) 6 31. Dete filed (Month, Day, Yeer)
KAR 0 2 1999



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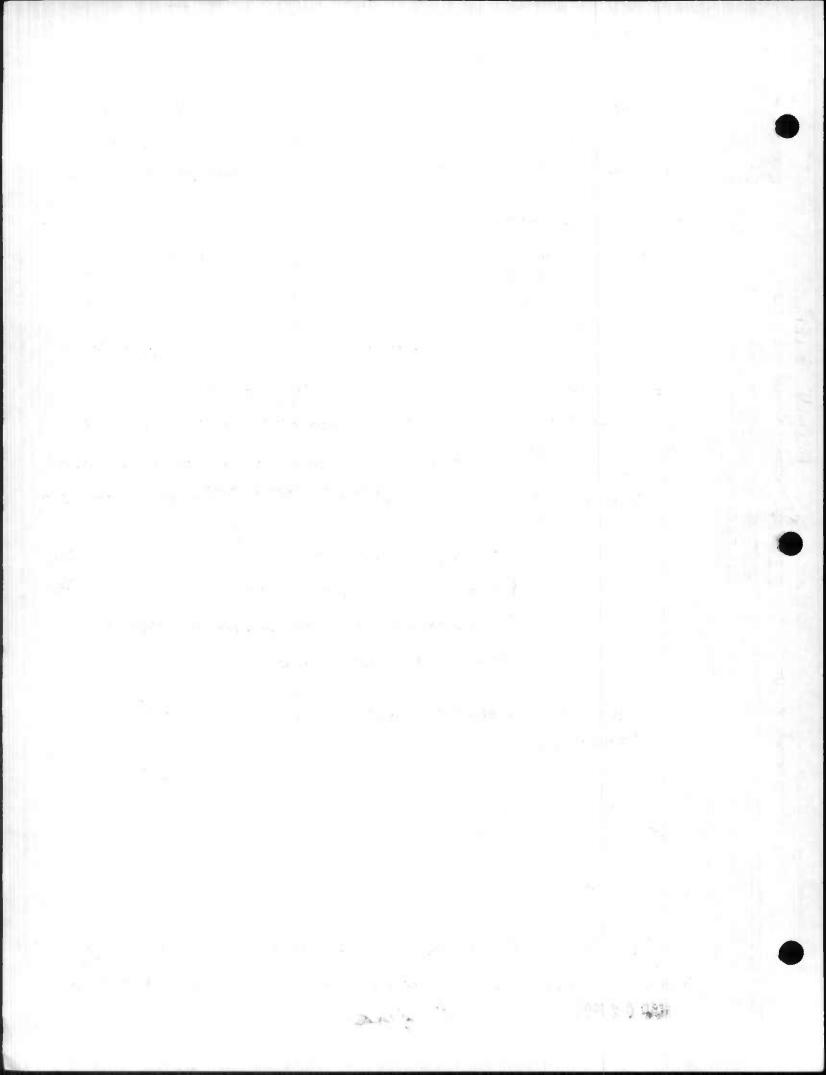
1 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.

2 Medical Examinar: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

29c. License number

29d. Dete signed (Month, Dey, Yeer)

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death MARCH 5, Physician WILLIAM THOMAS HEDRICK 1999 9:30 AM /Medical 4b. City, Town, or Locetion of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner Prince George's Southern Maryland Hospital Center Clinton Hours Min. 8. Dete of Birth (Month, Day, July 11, If Under 1 Yeer Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Deys 1**X** M 2 □ F 213-22-8359 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: if them 27 is merked other than "natural", or thems 23s or 28s-f show any injury or other traumatic event, the Medical Exercises. 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Prince George's Brandywine Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 16900 Summers Lane 20613 Funerai 12. Was Decedent Ever In U.S. Armed Forces? 1 M Yes 2 No 1946 -14. Rece - American Indien, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 11 Meditel Status 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: White P 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1967 Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Staff Sergeant U. S. Air Force 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Cecil Curtis Hedrick Mary Ruth Christopher 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Evelyn A. Hedrick/Wife 16900 Summers Lane, Brandywine, Maryland 20613 20b. Plece of Disposition (Neme of 20c. Location - City or Town, Stete 20a. Method of Disposition 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from Maryland Veterans' Cem. 03-11-1999 Cheltenham, Md 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licental The Huntt Funeral Home, Inc. 20604 M01095 P.O. Box 156, Waldorf, Maryland DAVID A. GOFF 23a. Pert1. Enter the disease, or complications that caused by deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each list. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediete Cause (Finel disease or condition resulting in deeth) Examiner Examiner Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieled events resulting in deeth) Lest Physician/Medical Due to (or es e consequença of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yss 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings eveileble prior to 24e. Wes en eutopsy performed? Completed completion of ceuse of deeth? 1 Yes 2 12 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 Pinpatient To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Neturel 5 Pending 1 ☐ Yes 2 No 2 Accident investigation 3 ☐ Sulcide 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

requires that the death certificate be executed physician and the bunal-transi Division of Vital Records, P.O. Box 68760, attanding pl signed by the a certificata has b irector, page 2 s Hospital or Attending Physician: funeral director, After this aftar death. n 24 hours aftar des ve Funeral Director pletely filled in by th

4 - Homicide 29e. Cartifier

(Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as steted Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and nyanner stated.

29b. Signeture and title of

29d. Date signed (Month, Dev. Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

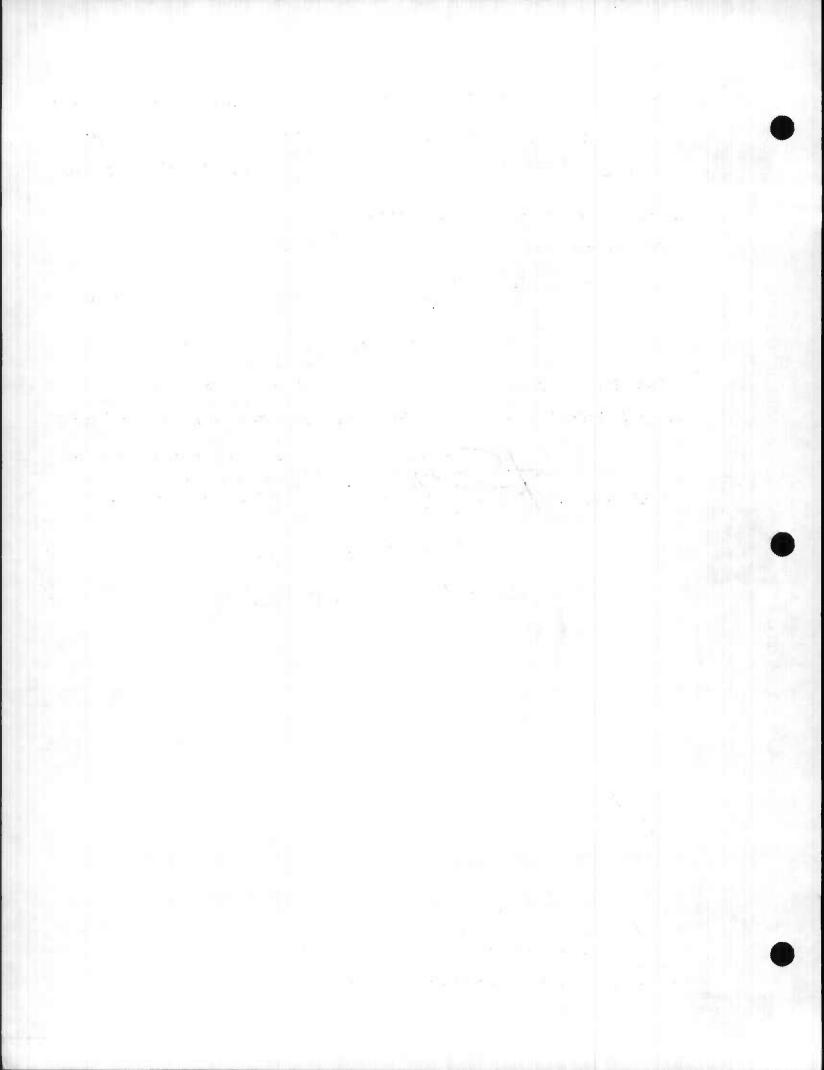
DANIEL M. HOWELL, MD, 11345 Pembrook Sq., #104, Waldorf, Md 20603 31. Dete filed (Month, Dey, Year)

State Registrar

Medicai

MAR 09 1999 32. Registrer's Signeture

To the Hosp within 24 ho To the Fune completely f



State of Maryland / Department of Health and Mental Hygiene

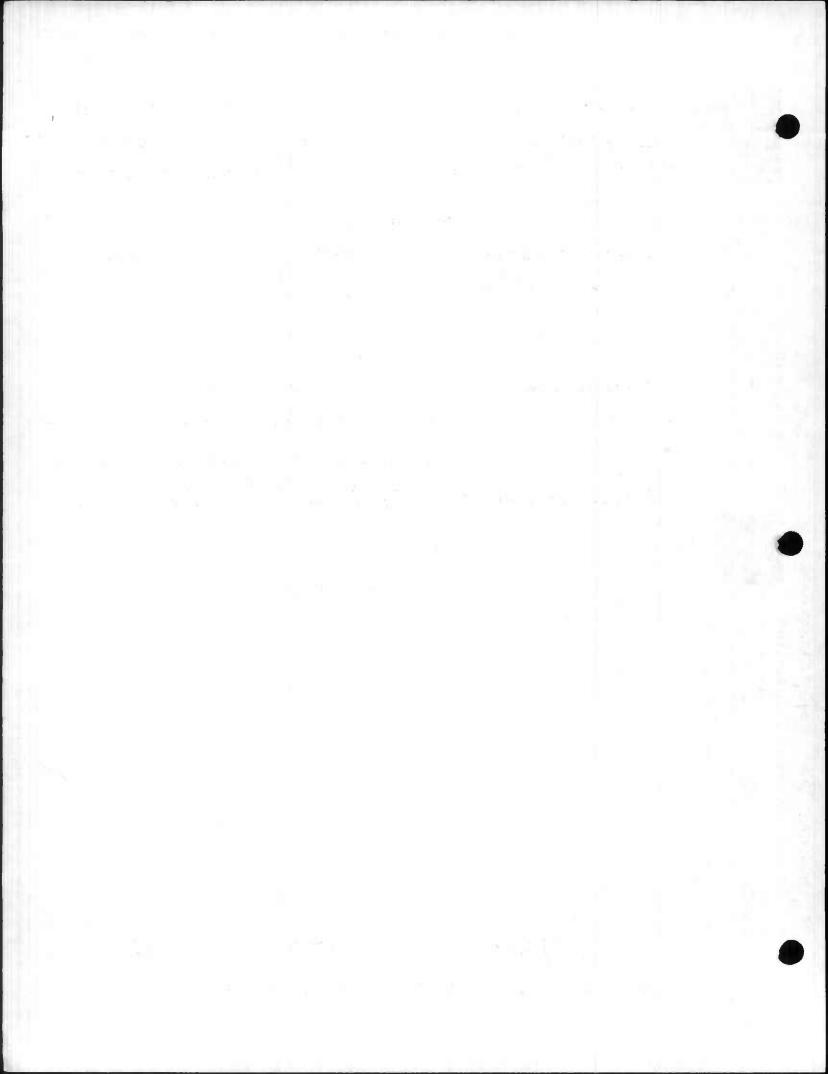
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey **Physician** Year Anna Catherine Herriman 28, 1999 Feb. 2:30 pm /Medical 4e. Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CIVISTA MEDICAL CENTER LAPLAIA

If Under 24 Hrs. 8. Date of Birth
(Month, Dey, Year)

Country)

Baltimore 5. Social Sacurity Number If Undar 1 Yaar 7. Aga (In yrs. last birthdey) **Funeral** Birthpiece (State or Foreign Country) Deys 1 □ M 2 ■ F 214-20-3028 71 Yrs. Director Usual Residence of Decedent 10a, Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ehov the Medical Examiner must be notified at 1 ☐ Yas 2 ■ No Director Maryland St. Mary's Mechanicsville the 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 9 25762 Baptist Church ROad or Herns 23a 20659 United States death Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yas 2 ■ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ■ No Specify: Specify by 3 Widowed 4 Divorced White naturel', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 12 Accountant Bookkeeping marked other 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Hant: If item 27 is marked oth Be Stanley Wollschlager Myrtle Miller 19e, Informent's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 le any injury or other trau once. James Herriman, Son 25848 Baptist Church Road, Mechanicsville, MD 20659 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ■ Buriai 2 Cremation 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Christ Episcopal Cemetery 3/4/99 Chaptico, Maryland 21. Signature of Funeral Service Licenses 22. Nama and Address of Fecility
Brinsfield Funeral Home, P.A. Thompson, Ur. Rohald L. M01154 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediete Cause (Final Nellmonia diseasa or condition resulting in deeth) **Examiner** Due to (or as e consequence of): Physician/Medical Examiner disease Kinsons Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): 68760 Due to (or es a consequance of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 2 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were eutopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 8 릒 1 Yas 2 No 1 Yas 2 No Vital 8 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 inpatiant Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 2 1 Yes 2₽ No 2 ER/Outpetient 3 DOA ō 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury et Work? Division Alber 5 Pending Investigation 1-2 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) or A 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es steted.

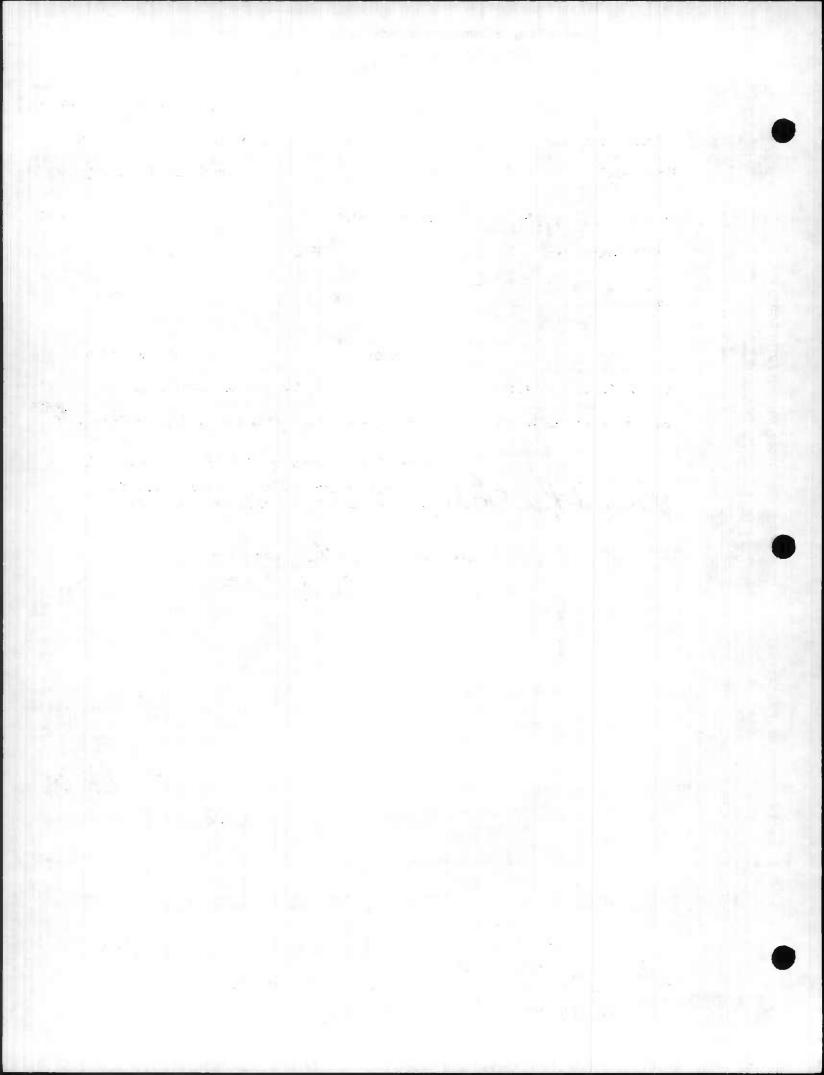
2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner stated. edicai 29a. Certifier (Check only one) 29b. Signature end fitle of 29c. Licansa number 29d. Data signed (Month, Dey, Year) D-22574 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Robert T. Pace, M.D. 31. Data filed (Month, Day, Year) 12070 Old Line Center Suite 202 Waldorf, MD 20603 32. Registrer's Signeture State MAR 02 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene

08776

			Cei	rtificate of	Death		Reg. No.			
	1. Decedent's Name (First, Middla, La	st)				2. Dete of De Month	eth Day	Yeer	3. Time of Death	
Physician /Medical	I	da Mae I	Harris				7, 1999	1001	6:55 AM	
Examiner	4a Facility Name (If not institution, giv	e street and number)	- 11		4b. City, Town, o	or Location of Death		of Death		
	38055 Beach Road	E			Colton	s Point	St.	Mary	y's	
uneral	5. Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Yeer	if Under 24 H	rs. 8. Dete of Bir	th Vacel	9. Birthp	iece (State or Foreig	
rector	215-46-3495	I□M 2□XF	86 Yrs.	Months Deys	Hours M	in. (Month, Da May 6	1912		land	
"naturel", or items 23s or 28s-f show sides Examinet must be notified at leted by Funeral Director	Usuai Residenca of Decedent									
	10e. State 10b. County	1	Oc. City, Town or Lo	cation				10	Od. Inside City Limit	
	Maryland St. Mai	ry's	Colton	s Point					1 ☐ Yes 2 🕅 No	
	10e. Street and Number			10f. Zlp Code			10g. Citizen of V	What Coun	try?	
	38055 Beach Road	1		20	0626	6 U.S.A.				
	11. Meritel Stetus	12. Wes Decedent Eve	er in U.S. 13)	Was Decedent of H	lispenic Origin?	(Specify Yes or No	- 14. Rac	e - Americ	an Indian.	
	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ② No	1	f Yes, specify Cuba	an, Mexican, Pu	erto Rican, etc.)		ck, White,		
	3 Widowed 4 Divorced	If Yes, Give		1□ Yes 2□XNo	Specify:		Specify	. Whit	te	
2			100 D-100	daania Harral Oaarra	- Ata-		40h Khadat B	rate a sadina	h. ata.	
Completed	15. Decedent's Ed (Specify only highest gra	ducation ide completed)	16a. Deced	dent's Usuai Occup kind of work done DO NOT use retired	during most of w	vorking	16b. Kind of Bu	usiness/inc	lustry	
d L	Elementary/Secondary (0-12)	College (1-4or 5+)			0)					
ပိ	10th		Ow	ner			Movino		oany	
Be	17. Father's Name (First, Middle, Last)					lame (First, Middle,		•		
2	Silas Potts	Newton			Ida	Belle S	mellings	5		
	19a. Informant's Name/Relationship (Type, Print)				Rural Route Numb			20020	
	Barbara Herbert	/Daughter	3805	5 Beach F	Rd, P.O.	Box 153,	Coltons	Poi		
	20e. Method of Disposition		20b. Plece of Dispo cametery, crer	sition (Name of	oal	Date	20c. Location -	City or To	wn, State	
	1 X Burial 2 Cremetion 3 C	JHemovel from State				3/10/99	771		77)	
	4 Donation 5 Other (Specif			Chapel Ce		13/10/33	Vien	na, \	/A	
MIST	21. Signature of Funeral Service Licer	isee P	0 M	2. Name end Addre	r-Gardin	er Funera	al Home.	P.A.		
oud	Muchant	orus Dard				ardtown,				
	2 Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused th	e dee . Do not ent	er the mode of dyir	ng, such as card	liac or respiratory e	rrest,	T	Approximete Interval Between	
ian	Shook, of Heart failule. Elst only	one cause on each mic.			,				Onset end Death	
cal	Immediate Cause (Final	0		. +	+	2212		1	1.1	
ner	disease or condition resulting in death)	e. mer	are we	~ www	a ny	July 2			ian	
a			ue to (or as a consec	quence of):	A . /	-				
두		b. Seve	u se	nill	Heme	nut			10grs	
Xai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Du	ue to (or as a consec	quence of):					0	
<u>e</u>	cause. Enter Underlying Cause (Disease or Injury	C						1		
edical Examiner	that initiated events resulting in death) Lest	Du	e to (or as e conseq	juenca of):				į		
Me		d						i		
an							1			
200	Part II. Other significant conditions of	ontributing to death but r	not resulting in the u	nderlying cause giv	ven in Part I.	23b. Did	tobacco use co	ntribute to	the cause of deat	
Physician						10	Yes 2 No	3 Prot	pably 4 Unkno	
by							1			
P							an autopsy med?		ere autopsy findings Bilable prior to	
Siet						pand		00	mpletion of cause death?	
Completed						10	Yes 2000	13	M Down	
	OF Wan ones minus district				00.71		2-	17		
Be	25. Was case referred to medical examiner?	Hospital:		_ 0#	nor:	Death (Check only		7		
2	1 Yes 2 No	1 L Inpatient	2 ER/Outpatier	II JUUA	4 U Nursing	1	denca 8 □Oth		/)	
0	27. Manner of Death	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	Wo		28d. Describe	how injury occur	rea		
at	Accident investigation			M 1	Yes 2□No					
=	3 Suicide 6 Could not b	e 28e. Piaca of Injury building, etc. (- At home, farm, etr	eet, factory, office		28f. Location (City or To	Street and Numb wn, State)	er or Rura	I Route Number,	
Certification:	0	outland, otor	Option 1							
edical (29a. Certifier Certifying Ph	yaldan: Terme best of r	ny knowledge, death kamination and/or in	n occurred at the til vestigation, in my o	me, date and pla opinion, death oc	ace, and due to the ocurred at the time,	cause(s) and ma date and place,	anner as st	ated. the cause(s)	
Me		and roomner state		200 Linns	a number	19	20d Date since	d /Month	Day Vent	
-	29b. Signature and title of pertifier			29c. Licens	e number		29d. Date signe	(MOVIE),	Lucy, relate)	
	1/1	>4		1/	9917		3/8	199		
	30. Name and address of peryon who	completed cause of deal	h (item 23a) (Type,	Print)			1/			
	Vames C.	Boyd, MD		Californ	nia. MD	20619	1			
tate	31. Dete filed (Month, Day, Year)	32. Registrar's	Signature	~~~~~~~						
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State of Maryland / Department of Health and Mental Hygiene

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	Physician	Decedent's Name (First, Midd							2. Date of Death Month Day Year			3. Time of Death				
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	Examiner	4a Facility Name (If not institution	n, give street and numb	oer)			4b. City, Tov	vn, or Location	on of Death	4c. County	of Death					
All .		ROUTE 40 & 3	EFFERS STR	EET			ELKTO	NC		CEC	TT.					
	Funeral Director	5. Social Security Number 413-68-1380	ear If Under 2 ays Hours	24 Hrs. 8.1 Min.	Date of Birt Month, Da		9. Birthp Cour	placa (State or Foreign ntry) nnessee								
70	5-0020 72 hours effer deeth with the Meryland natural, or items 23s or 28s-f show sidel Examiner must be notified at	Usual Residence of Decedent														
ryten		10a. State 10b. County		10c. City,	Town or Loc						1	10d. Inside City Limits				
W.		Maryland	Cecil			No	rth Eas	t				1 ☐ Yes 2]() No				
5	or 26	10e. Street and Number				10f, Zip Co	de			10g. Citizen of V	What Cour	ntry?				
iy d	23.8	3 Bartham Cour	t, Irishtow	vn Road			21901			U.	S.A.					
990		11. Maritel Status	12. Wes Decede Armed Force	ent Ever in U,S.	13. W	Vas Decedent	of Hispanic Orig Cuban, Mexican	in? (Specify	Yes or No	14. Rec	e - Americ	can Indian,				
21215-0020 d within 72 hours effer	ar, or it.	3 ☐ Widowed 4 🖾 Divorcad	rled 1 ☐ Yes 2	O ∑No			No Specify:	, 1 20110 1 1100	in, otoly	Specify		hite				
5-0	ted teatur	15. Deceder	t's Education		16a. Deced	ent's Usual O	ccupation	of working		16b. Kind of Bi						
121	ygiene. or than "natur. nt, tra Medical.	Elementary/Secondary (0-12)	st grade completed) College (1-4	or 5+)	life. D	O NOT use n	one during most etired)	or working				ng & Siding				
21 M	Hygien, ther the	Ten Years				Roofe	r			Port De	posit	t, Maryland				
Maryland	T to S	17. Father's Name (First, Middle,	Last)				18. Mothe	r's Name (Fi	rst, Middle,	Maiden Surnam	10)					
/a	marked marked matic ev	Roy	Hammons					En	ıma Wi	llen						
an	t bue	19e. Informant's Name/Relations	ship (Type, Print)		19b. Mallin	g Address (S	reet and Numbe	r or Rural Ro	oute Numbe	er, City or Town,	State, Zip	Code)				
M 2	27 le	Velma Farmer (Sister)	0.00	65 Li	nton R	un Road	, Port	Depo	sit, Ma	rylar	nd 21904				
Baltimore,	of Heelth item 27 other tr	20a. Method of Disposition		20b. Plac	ca of Dispos	sition (Name of	of place)	0	ate	20c. Location -	City or To	own, State				
mo age	2 = 5	1 Buriel 2 Cremetion 4 Donation 5 Other (5					etery	3/6	/99	Perrvvi	11e.	Maryland				
=======================================	Depertmen important: any injury ance.	21. Sign ture of Funeral Service					ddress of Fecility				,					
Be	Dep Aug	1	on Fu	neral H	lome											
		Perryville, Maryland 21903-0188 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.														
		shock, or heart failure. List		Approximate Intervel Between Onset and Death												
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		resulting In death) Due to (or as a (amsequence of):														
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acut	hysician end the buriel-trensit	Sequentially list conditions,	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): Due to (or as e consequence of):													
90,	cian	cause. Enter Underlying Cause (Disease or Injury	G.													
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. 8	9 9 -	Part II. Other significant condition	ons contributing to deat	h but not resulti	ing In the un	derlying caus	e given in Part I.		23b. Dld	3b. Did tobacco use contributa to the cause of death						
P. A	ed by the deteched								10	Yes 2□ No	3 Pro	bably 40 Dnknow				
S t	signed by be det										_					
Records, P.O	page 2 should								24a. Was	an autopsy rmed?	av	ere autopsy findings reliable prior to				
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	page 2								16	Xes 2□No	1,1	Yes 2 No				
ta	certificate rector, pa		1				26 Place	of Death (C	heck only	nne)	6	1				
of Vital	nis cert il direct	examiner? 1 XYes 2 No	Hospital: 1 Inp	nationt 2 FF	R/Outpatient	3□ DOA	Other			denca 6 🖸 Ott	ner (Sneol	N com				
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OD	After a funer	1 □Natural 5 □ Pendia 2 M Accident Investi	gation 3/2/9	Day Year)	Injury	м	Work? 1 ☐ Yes 201	No ~	religh	near Itu	ichil	yvelich				
Division or Attending	death ctor: A y the f	3 Suicide 6 Could	not be 28e. Placa of	I tnjury - At hom , etc. (Specify)	e, farm, stre	et, factory, of	fice	281.	Location (Street and Nyml	ber or Ryn	al Route Number,				
O S	din din terti	4 ☐ Homicide	building	, etc. (Specify)		board	way	9	City or To	vn, State)	ter.	+ Jeffer				
pite	within 24 hours effer death. To the Furerel Director: Affer t completely filled in by the funers Medical Certification:	29a. Certifier 1 ☐ Certifyli	ng Physician: To the be	est of my knowle	edge, death	occurred at t	ne time, date and	d place, and	due to the	cause(s) and m	anner as s	stated.				
, H	Fur etely	(Check only 2 Medical one)	Examinar: On the basi	s of examination	n and/or Inv	estigation, in	my opinion, deal	th occurred a	t the time,	date and placa,	and due t	o the ceuse(s)				
o the	ithin o the					29c. Li	cense number			29d. Date signe	d (Month,	Day, Year)				
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	2	1 hade	uMit	79 m	2		··C·M·E·			MARC	H 3,	1999				
	L	30. Name and address of person		of death (Item 2	3a) (Type, F	Print)										
			E Miken	7	111	Penn	Street,	Bal+	more	Maryla	and 2	1201				
	State	31. Date filed (Month, Day, Year,	32. Reg	jistrar's Signatui	1	-11				1	and the					
	Registrar	MAR 0 8 1999	Legen	N.	100	PURS!										



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedenl'a Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** 1999 7:55 A.M. Hayleigh Snow Heinz March /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery If Under 1 Yaar | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 2-9-99 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birtholaca (Stata or Foraign **Funeral** Months Hours Mary land Yrs. Newborn Director Usual Rasidence of Deceden 10e State 10b. County 10c. City. Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Estamber must be notified at 1 Yaa 2√ No Director Crofton Anne Arundel 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Hygiene. other than "natural", or flama 23a or USA 1910 Cavalier Circle 2 111 4 Funeral 11 Marital Status 12. Waa Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yaa or No-II Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 72 hours efter 1 Yas 2 XNo Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent'a Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 end 2 should be filed wit Department of Health and Mental hygiens Important; if item 27 ie marked other tha eny injury or other traumatic event, that page. 0 Never Worked 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be Kelly Janine Snow Kevin David Heinz 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 1910 Cavalier Circle Crofton MD 21114 Father / david Heinz 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) Data 20c. Location - City or Town, Stata 1 XBurial 2 Cremation 3 Removal from State Rolling Green Cemeter 3-6-99 4 ☐ Donation 5 ☐ Other (Specify) Camp Hill, Pa. 21. Signalure of Funeral Septice Licenses R. T. Foard Funeral Home, P. A.

111 S. Queen St., Rising Sun, MD 21911

Se, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

List only one cause on eech line. 22. Nama and Address of Facility Approximate Interval Batween Onset and Death **Physician** Immediata Cause (Finel /Medical 20 days disease or condition resulting in death) Examiner Dua to (or as a consequence of): Examiner Respiratory 20 day physician and the burief-transit lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Box 68760 monary Physician/Medical Due to (or as a consequence of) 987 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Records, P.O. signed by t 1 Yea 2 No 3 Probably 4 Unknown à 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed 1 Yes 2 No 1 Yea 2 No certificate Division of Vital or Attending Physician: 25. Was casa refarred to medical 8 26. Placa of Death (Check only ona) axaminer? Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To this After thi funeral 27. Manner of Death 28a. Deta of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at WA 5 Pending Natural 1 ☐ Yes 2 ☐ No death. investigation NAM To the Hospital or Attendition 24 hours efter death.
To the Funeral Director: A completely filled in by the fu NA 2 ☐ Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 ☐ Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the causa(s) and manner stated. 29b. Signatura and titta of certifier 29c. License number 29d. Data signed (Month, Day, Year) 14516194

Registrar DHMH 16 Rev 6/95

State

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Forest blen Rd, Silver Spring, MD

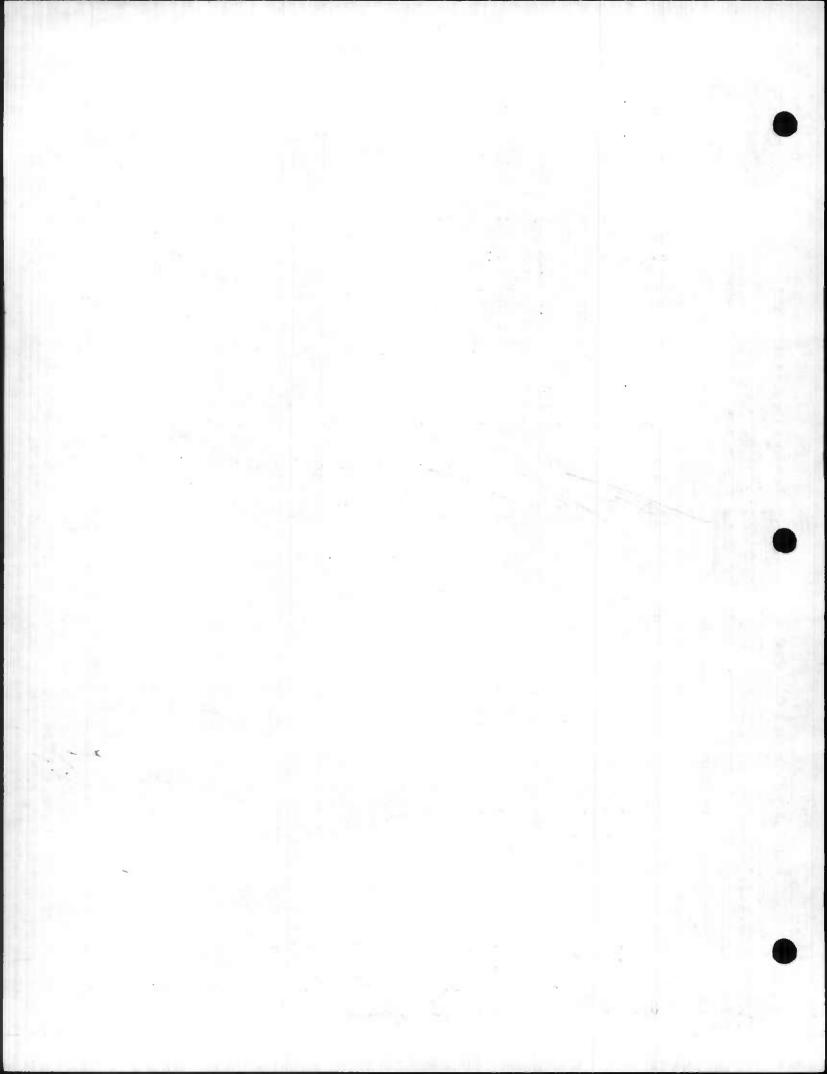
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 32. Registrer's Signature

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31. Data liled (Month, Day, Year) MAR 0 3 1999



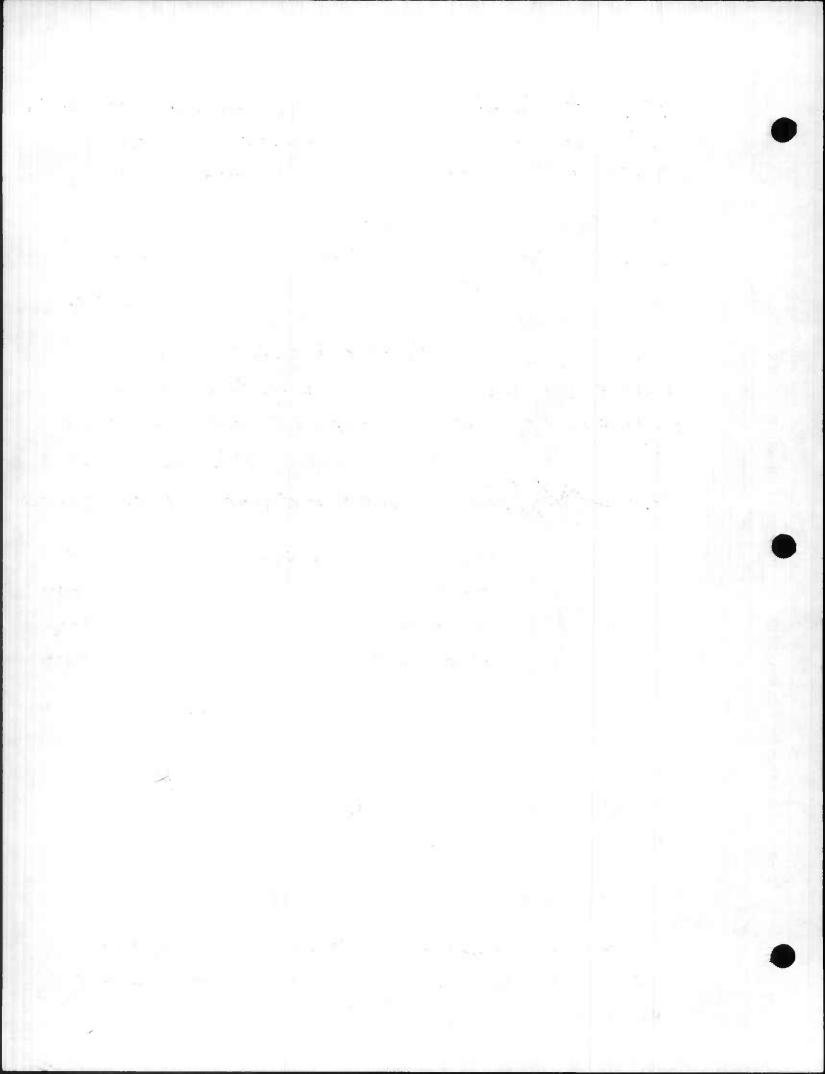
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death J8 Month Year **Physician** 0049 February 4c. County of Death /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner ELX+ON
If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) HOSPITAL UNION Birthplaca (State or Foreign Gountry) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Sex 112 M 2 F **Funeral** Months Deys 236-22-311 Director Usual Residence of Deceden the Maryland 10b. County 10c. City, Town or Location 10d. Inalde City Limits 10a. State permit. Pages 1 and 2 ahould be filed within 72 hours after deeth with the Marylan Department of Health and Mentel Hygiane.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at page. 1 Tea 2 No ELKTON Directo CECIL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 192 14. Race - American Indian, 101 COX Funeral 13. Was Decedent of Hispanic Origin? (Specify Yea or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dates: 11. Marilal Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHI te þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Eiementary/Secondary (0-12) College (1-4or 5+) RESTAURAN OWNER 18. Mother's Name (First, Middla, Maidan Surname) 17. Fether's Nema (First, Middle, Last) Be ELIZABETH 2 Moses Headley Ne (SON 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) - MANKLIN HEADLEY -50N 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 21921 ECKTON MO. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Ramoval from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Cemetery 21. Signature of Funeral Service Licenses GEE FUNERAL Home 259 E. MAIN ST. ELETON Weter 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. Est only one cause on each line. Approximata Interval Between Onset and Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical How Examiner Due to (or es e consequence of) Examiner 20120 physician and s the buriel-transit The law requires that the deeth certificete be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Engly sene Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as e consequença of): for use es ASVD, ACCUD. signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i. Yes 2 No 3 Probably 4 Unknown þ 24b. Wera autopay findinga aveilable prior to completion of cause Completed 24e. Was an autopsy performed? s cartificete hes b director, page 2 s of death? 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this cartifice funeral director, 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 1 Inpatient 2 ER/Outpatient 3 DA Certification: To 27. Menger of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 2 Accident 5 Pending Investigation 2 No 3 Suicida 6 Could not be determined 28e. Placa of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Routa Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and placa, end due to the ceuse(s) end manner as atated.

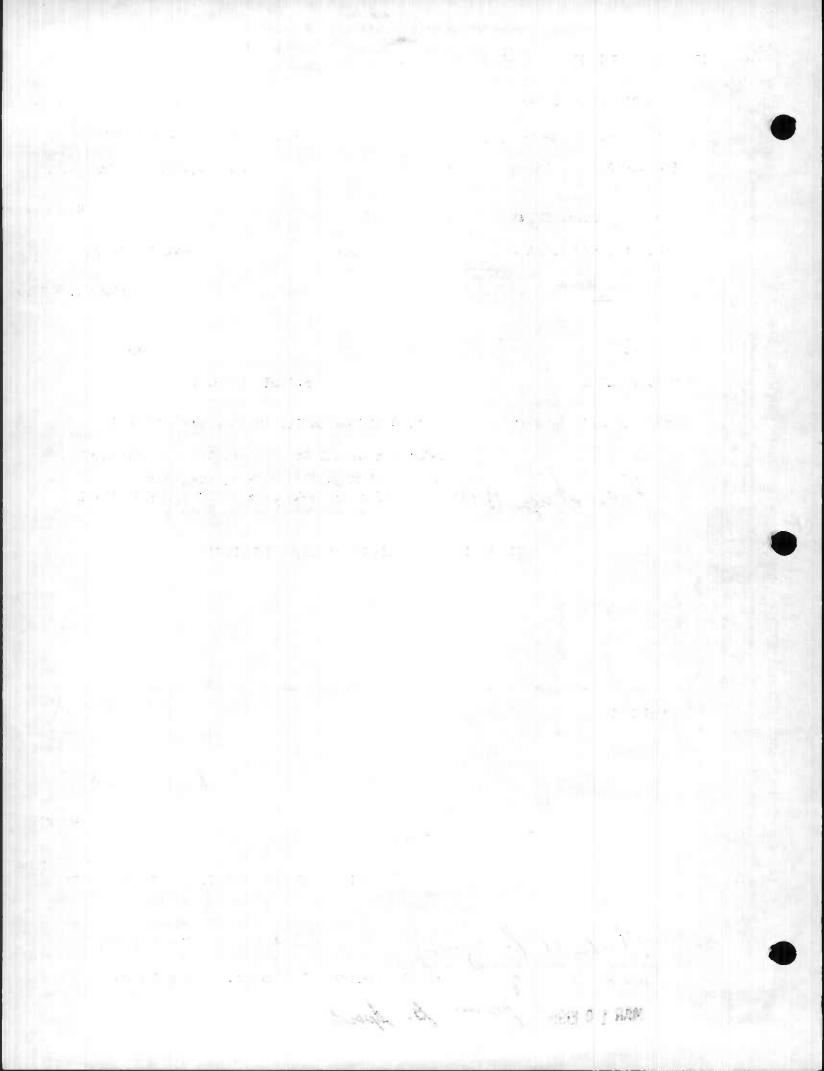
Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a Cartifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of cartifier Tru chil Har MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 JUI MD West main st, Elkton Md CHIH HSU 31. Date filed (Month, Dey, Yeer) 32. Registrer's Signeture State MAR 0 3 1999

DHMH 16 Rev 6/95

Registrar



DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** William 411 Peloruary 0915 /Medical 4e. Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** of Maryland Medical Systems university Baltmore if Under 24 Hrs. 8. Date of If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1√2 M 2□ F Days Hours 69 Director 228-32-8223 VIRGINIA OCT, 19,1929 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examiner must be nothed at Director 1 Yes 2 No MARYLAND BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 1414 DRUID HILL AVENUE 21217 U.S.A.12. Wes Decedent Ever in U,S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Orlgln? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 5 1 end 2 should be filed within 72 hours efter Health and Mental Hygiene.
lem 27 is marked other than "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ Specify: AFRO AMERICAN 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) OYSTERING SEAFOOD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 GEORGE A. HILL SR. FANNIE COLEMAN 19a. Informent's Name/Relationship (Type, Print) permit. Pages 1 end 2 sh. Department of Health and Important: If Item 27 is m any injury or other traum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GENEVIEVE JOHNSON 5918 IRVINGTON ROAD WHITE STONE, VA 22578 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete Burial 2 ☐ Cremetion 3 ☐ Removel from Stete MAR. Donation 5 Other (Specify) VERNON BAPTIST CHUR CH 1999 WHITE STONE of Funeral Service Licenses 22. Name end Address of Facility BERRY O. WADDY 6784 MARY BALL RD LANCASTER, POB 305 VA 22503 23e. Part1. Enter the dilease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting In death) /Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events bunial-tran Due Kespiratoru railu Physician/Medical the resulting in deeth) Last for use as alland Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 6 1 Yes 2 No 3 Probably 4 Unknown railure þ Completed 24b. Were autopsy findings available prior to 24e. Wes an autopsy performed? Seizure disorder completion of cause of death? Closed head 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To al or Atto.
Jurs efter death.
The function of the second o 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Netural 5 Pending investigation 28 Accident 02/12/99 1 Yes 2 No rall 6 Could not be determined 3 ☐ Suicide 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Home 535 Wilson St. Bathmore, Md

Box 68760. P.O. of Vital Records. Division

Attending Physician: The law requires that the death certificete be

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certificate

this

physician

death

Baltimore, Maryland 21215-0020

To the Hospital within 24 hours e To the Funeral D

Medical

31. Dete filed (Month, Day, Year State MAR 0 5 1999

29a. Certifier (Check only one)

29b. Signature end title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. 29c. License number 29d. Dete signed (Month, Day, Year)

30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print)

22 South Greene Street Baltimore, Md. 21201 1 andon MD 37. Registrar's Signeture

Registrar

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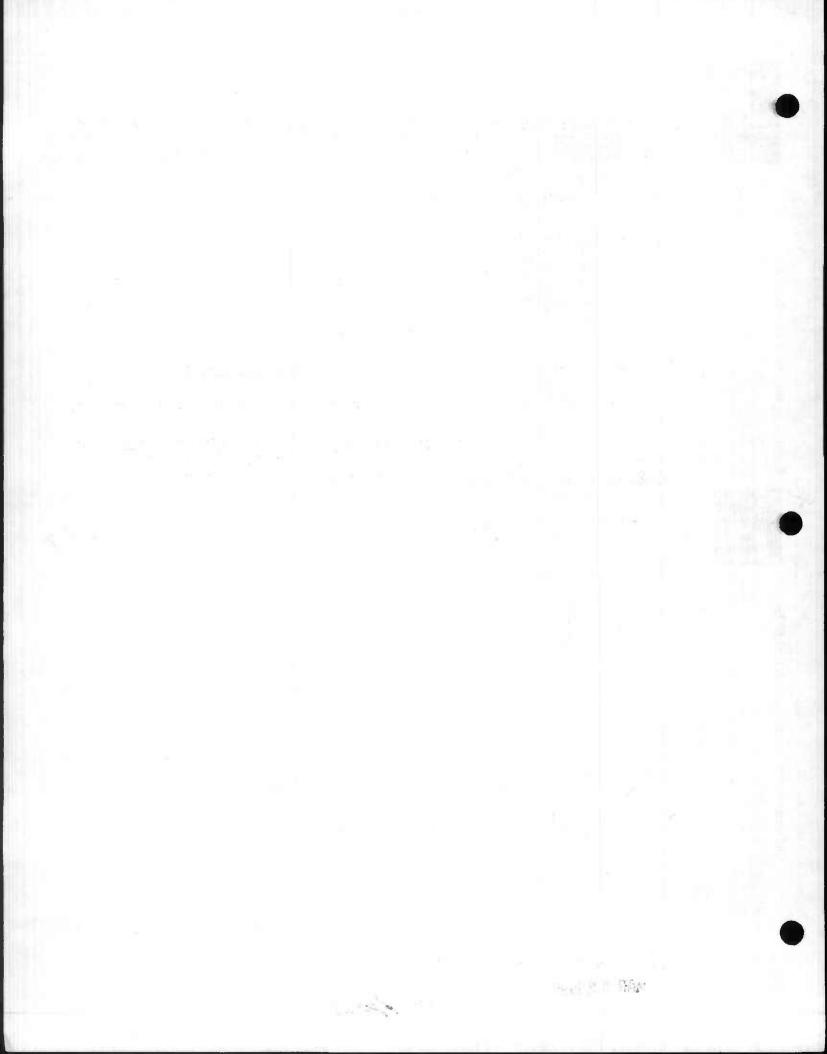
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2		30. Name and address of person who Michael Grad	MD 4910	Massach		ts Ave	. Wa	shingt	on, D	C		
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State of Maryland / Department of Health and Mental Hygiene

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al or Attending s after death. Il Director: After ed in by the fune	Certification:	3 Suicide 4 Homlolde 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)					mber,
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-		1 Ann	1 /	of Herel	en m	0		D	477 9	9/	1 February 24, 199 The MD			999	
(5)		30. Name and address of p	erson who	completed cause o	f deeth (iter	m 23e) (Type	Print)	ill	, Rock	cv7/6	e m	0	0		
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State of Maryland / Department of Health and Mental Hygiene

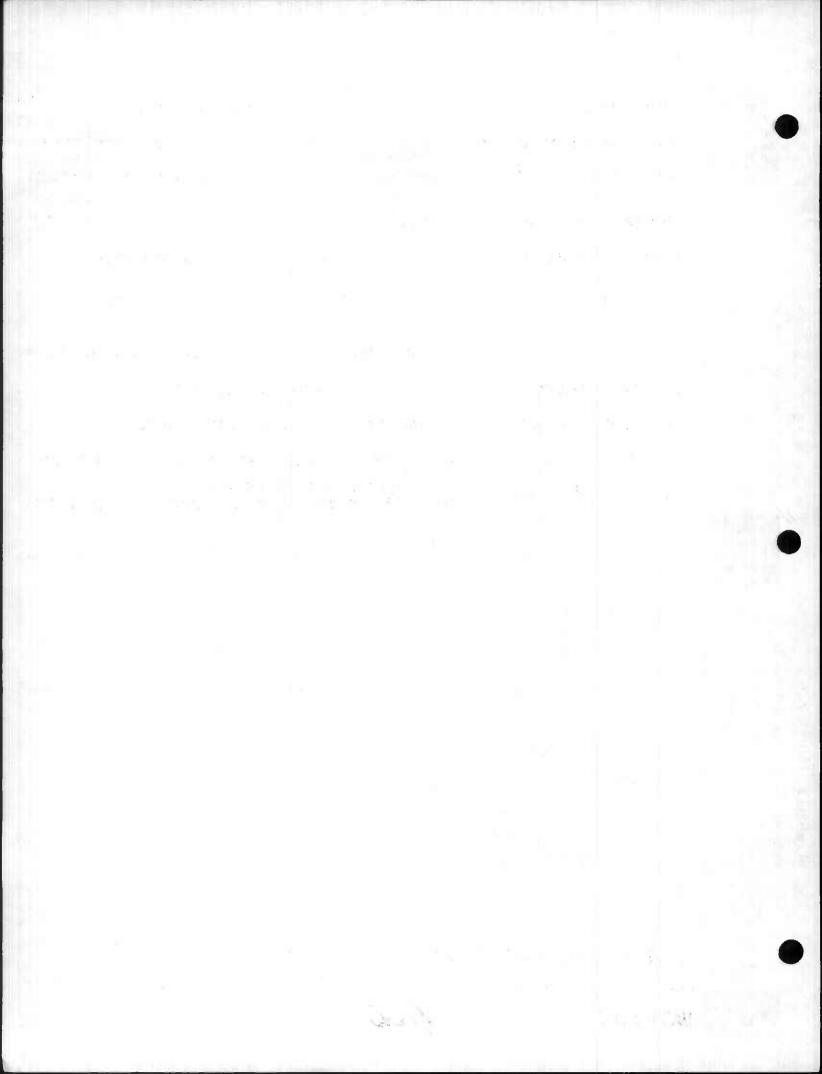
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 8:55 P.m. **Physician** Month February JANICE RUTH HIGGINS 1999 aT /Medical 4e. Fecility Neme (If not Institution, giva street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON COUNTY 5. Sociel Security Number If Under 1 Year | If Undar 24 Hrs. 7. Age (In yrs. last birthdey) Birthplece (Stete or Foraign Country) 8. Deta of Birth (Month, Dey, Year) **Funeral** 1□ M 2X F Deys Yrs. Director 579-46-2003 61 JAN. 31, 1938 WASHINGTON, DC Usuel Residence of Decedent Maryland 10e State 10b County 10c. City, Town or Location 10d. Inside City Limits maint be notified at Director 1 ☐ Yes 2 No MARYLAND WASHINGTON HAGERSTOWN the 10a. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? filed within 72 hours after death with 10311 COLD HARBOR DRIVE 21740 Funeral UNITED STATES items ; 12. Was Decedent Ever in U.S. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Bleck, White, etc. Armed Forces?

1 Yas 2 No
If Yes, Give r than "natural", or iten the Medical Examiner 1 ☐ Never Merried 2 ☐ Married 21215-0020 1 ☐ Yes 2 X No Specify: þ Specify: 3 ☐ Widowed 4 🗓 Divorced WHITE Yaar or Datas: Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 12 CONSULTANT LIFE INSURANCE COMPANY 7 is marked other traumatic event, Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surnema) Be Pages 1 and 2 should be nent of Health and Mental 2 JOHN JOSEPH BRENNAN RUTH JANE McGINELY 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) nt of Health a :: If item 27 is r or other tra MICHAEL HIGGINS, SON 1011 MERCER PLACE, FREDERICK, MARYLAND 21701 20e. Method of Disposition 20b. Pleca of Disposition (Name of cametery, cremetory or other pleca) 20c. Location - City or Town, Stata 1 🖁 Buriel 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of important: if eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) FORT LINCOLN CEMETERY 3/4/99 BRENTWOOD, MARYLAND 21. Signeture of Funeral Service Licensia 22. Name end Address of Fecility FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722 23a. Part Enter the disease, or commications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert feilure. List only ne ceuse on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediete Ceusa (Finel · LUNG CARCINOMA WITH ABDOMINA METASTASIS disaese or condition resulting in deeth) Examiner Due to (or es e consequenca of): Examiner requires that the death cartificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest bunai-tran Due to (or es e consequence of): attending physician for use as the burie Physician/Medical Due to (or es e consequença of) P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? by 1 Yee 2 No 3 Probably 4 Unknown PNEWMONIA ð 24b. Were eutopsy findings eveilable prior to Completed 24e. Wes en eutopsy peen ADDISON'S SYNDRUME completion of cause of deeth? The law r certificate has 1 ☐ Yas 2 ☑ No EMPHYS.EMA 1 ☐ Yes 2 No of Vital 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) P 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA al or Attending Physical States death.

ii Director: After this ed in by the funaral di this 27. Manner of Deeth 28e. Dete of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury et Work? Division 5 Pending invastigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Straet end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 ☐ Homicide To the Hospital of within 24 hours of To the Funeral DI 1 Le Certifying Physician: To the best of my knowledge, deeth occurred at tha time, dete end pleca, end due to the ceuse(s) and menner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and pieca, end due to the cause(s) end menner stated. Medical 29a. Certifier complataly (Check only one) 29b. Signature end title of cartifiar 29c. Licensa number 29d. Data signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 251395 WILLIAM E. ROYSTEN JA. M.D. 11110 MEDICA CAMPUS RO, SUIZE 107. HACESTOWN MO 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State Registrar MAR 0 2 1999

HIGGINS, Janice

DHMH 16 Bay 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Robert Nevin HAGERMAN, Jr. 0930 3 1999 March 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1⊠M 2□ F Months 214-09-3530 80 21, 1918 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14C Milestone Garden Apartments 21795 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) administrator nursing home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert N. Hagerman, Sr. Florence Rettig 19a. Intormant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert N. Hagerman, III - son 148 S. Mulberry St., Hagerstown, Md. 21740 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑Cremetion 3 ☐Removal from Stete 4 Donation 5 Other (Specify) 3-4-99 Hagerstown Crematory Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedieta Cause (Final disease or condition resulting in death) Lyhoris CBABRO VASCULAR Acci DBW Hear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events REWAL FAILURE 3449,45 thet initieted events resulting In death) Last Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown hay 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 200 No 1 ☐ Yes 2 No 26. Place of Deeth (Check only one)

Physician /Medical Examiner

permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked of

Physician

/Medical

Examiner

Funeral

Director

28a-1

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"natural", or items 23s

Baltimore, Maryland 21215-0020

Directo

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Examiner **Physician/Medical** þ Completed Be

physician and s the burial-transit Medical Certification: To

Division of Vital Records, P.O.

this

Hospital or To the Hospital within 24 hours or To the Funeral I completely filled

Robert

agerman

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 SNatural 5 Pending investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

MAN2AR 31. Date filed (Month, Day, Year) MAR 0 4 1999

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

29b. Signature and title of certifier

JSHARI 32. Registrar's Signature

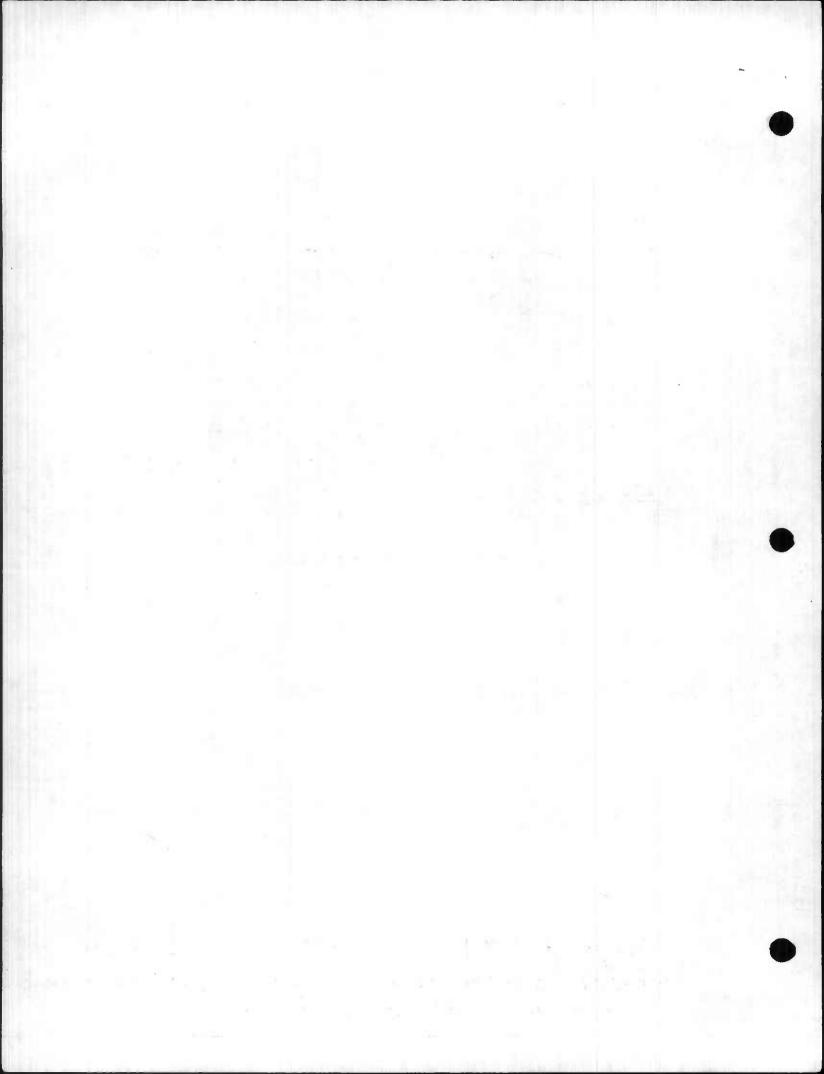
368 MILL STREET HAGERS TOWN MOZINGO

29c. License number

D28365

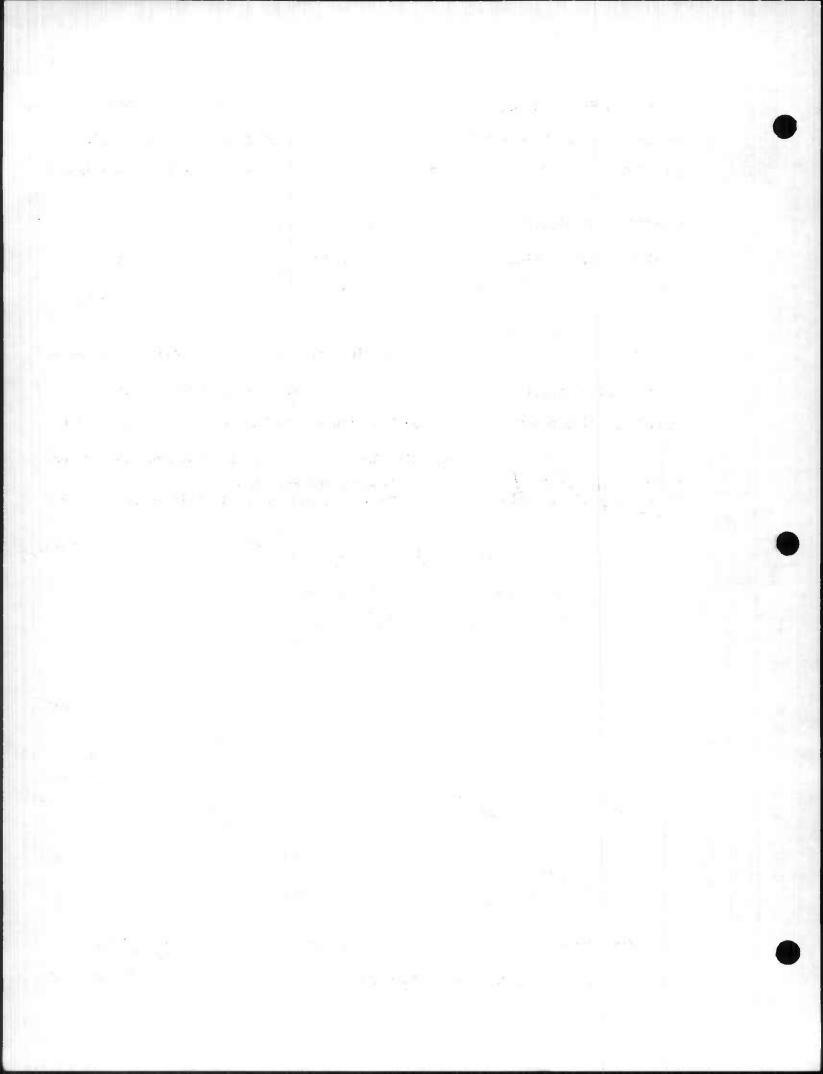
29d. Date signed (Month, Day, Year)

3 - 3 - 99



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Benjamin Franklin Howell March 8-20 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown Western Maryland Hospital Center Washington | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Deys Hours Min. Feb. 20, 1924 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** 1 M 2□ F Mary land 75 Yrs. Director 220-16-3859 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Washington Hagerstown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16618 National Pike 21740 USA death Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married 21215-0020 1 Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) 8 Refinisher i. Pages 1 and 2 should be filed w tment of Health end Mental Hygier tant: If Item 27 is marked other th Jury or other traumatic event, the Leather Processing Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lee Hampton Howell Neva Elrita Roper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Edgar Howell/Brother 16612 National Pike Hagerstown, Maryland 21740 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page Depertment of Important: If any Injury or 3-10-99 Hagerstown, Maryland 4 Bonation 5 ☐ Other (Specify) Rose Hill Cemetery 22. Name and Address of Facility
Osborne Funeral Home 425 S. Conococheague St.Williamsport, MD 21795 Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, mack, or heart failure. List only one cause on each line. Physician Immediate Cause (Finel disease or condition resulting In death) /Medical Examiner Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed buriel-transi Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 eup Physician/Medical the Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, should be d by 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Wes an autopsy performed? Completed page 2 certificate 1 Yes 2 No 1 Yes 2 No of Vital 25. Wes cese referred to medical Be 26. Place of Deeth (Check only one) P 2 - No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 ☐ bpstrent 2 ☐ ER/Outpatient 3 ☐ DOA this filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death Medical Certification: 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? After Division 1 PNatural 5 Pending investigation 1 Yes 2 No 24 hours after death. Funeral Director: A 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier within 2 To the 29b. Signature and title of cert 29d. Date signed (Month, Dey, Year) 29c. License number 30. Name end address of person who completed ceuse of death (Item 23e) (Type, Print) MILL ST. HAGERSTOWN 350 PKANCISCO AUDKADZ 31. Date filed (Month, Dey, Year) 32. Registrer's Signature State Registrar MAR 0 9 1999



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Date of Death 3. Time of Death March 7, Day 1999 **Physician** DOROTHY CAMILLA HAMILTON 6:40 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood Retirement Center Williamsport Washington If Under 1 Yeer If Under 24 Hrs. 8. Data of Birth
Months Deys Hours Min. January 5. Social Sacurity Number 6 Sex 7. Age (In yrs. iast birthdey) 9. Birthpleca (State or Foreign Country) 2 Maryland **Funeral** 1□M 2□F Months 13.1932 220-28-9283 67 Yrs. Director Usuel Rasidence of Decedant 10a Stata 10h Counts 10c. City, Town or Location 10d. Inside City Limits Maryland Washington 1 Yas 21 No Williamsport Director 10e. Street end Number 10f. Zlp Coda 10g. Citizan of What Country? r than "natural", or items 23s or the Medical Examiner must be 16505 Virginia Avenue 21795 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forcas? 14. Raca - American Indian, 11. Meritel Status Was Dacedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 Married specify: White 1 Yas 2 XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry College (1-4or 5+) Elamentary/Secondary (0-12) Teacher Public Schools 17 Fathar's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be Daniel Frederick Keefauver Mary Frances Martin 0 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) riant: If Itam 27 is 937 St. Clair Street, Hagerstown, Md. 21742 William C. Hamilton 20b. Place of Disposition (Name of cematary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 A Cremetion 3 ☐ Ramoval from State 6 4 ☐ Donation 5 ☐ Othar (Specify) 03-08-99 Smithsburg, Maryland Smithsburg Crematorium 21. Signature of Funeral Sarvice Licensi 22. Nama and Address of Eaglity Andrew K. Coffman Funeral Home, Inc. noch 40 East Antietam Street, Hagerstown, 21740 Md. 23a. Part1. Entar tha diseesa, or complications that caused the deeth. Do not entar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Deeth **Physician** /Medical Immediata Causa (Final disease or condition resulting in death) Examiner ULLA Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Cause (Disease or injury that initiated avants rasulting in daath) Last Dua to (or as a consequanca of) physician s the burial TASTATIO (weak Physician/Medical Dua to (or es e consequence a cur Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed by > CKENURIC þ 24b. Wara autopsy findinga evaileble prior to Completed 24a. Was en eutopsy completion of cause of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical Be 26. Piaca of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 쿭 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? Affair 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No Investigation 2 Accidant 6 Could not be 3 ☐ Sulcida 28a. Ptace of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) after Direc 4 Homleide To the Hospital within 24 hours a To the Funeral D edicai 29a. Cartifian 1 🖰 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as statad. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signatura 29c. Licensa number 29d. Data signed (Month, Day, Year) (MEGIN 30. Nama and propleted causa of daath (Itam TEPHENE. METZIVEN 32. Aagistran's Signeture 31. Data filed (Month, Day, Year) State Place MAR 0 9 1999

Registrar



0 351E 7

Adrian	Johnson	ART I, 27, 28A-F PER			-	artment of rtificate of	Health and I Death		giene 9	08	789	
	Physician	1. Decedant's Nama (First, Midd Adrian L. Joh	ia, Last)	,				2. Data of De		Yaar	3. Time of Death 3:20 P.M.	
	/Medical Examiner	4e Facility Nama (If not institution		u <i>mber)</i>			4b. City, Town, or I	ocation of Death	4c. County	of Death		
		Prince George'	s Hospita	1. Cente	er		Chever	-d	Pri	ince G	eorge's	
	Funeral Director	5. Social Sacurity Number 579–92–1599	7. Age (In yrs 37	. last birthday) Yrs.	Months Days		8. Deta of Bird	th y, Year)	9. Birthpla Countr Wash	ce (Stete or Foreign y) .,D.C.		
	pus *	Usual Rasidance of Decedant 10a. Stata 10b. County		10c. C	ity, Town or Lo	ocation				100	d. Insida City Limits	
	Aarylar Febow	D.C. N/			Washi						1 XYas 2 No	
	or 28a-f elements of Director	10e. Street and Number			VIGO112	10f. Zip Coda			10g. Citizen of	What Countr	y?	
	23a or	910 Hami	lton St.,	N.E.		20011			U.S.			
50	filed within 72 hours after deeth with the Maryland Hygiane. ther than "natural", or items 23a or 28a-f show ant, the Medical Examinet must be northed at any Completed by Funeral Director	11. Marital Stetus 1 Navar Married 2 Mar 3 Widowad 4 Divorced	ried 1 🖾 Yas	2 No		Was Decedent of If Yas, specify Cu 1 ☐ Yas 2 🕍 No	Hispenic Origin? (S. ban, Maxican, Puarto Specify:	pecify Yas or No o Rican, etc.)	- 14. Rac Ble Specif	ce - American ck, White, at y: Bla	tc.	
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15	led within 72 ho tygiana. The than "natur. It, the Madical.	(Specify only highe	it's Education st grada complated		(Giva	dant's Usual Occu kind of work done DO NOT use ratir	a during most of wor	king	16b. Kind of B	usiness/indu	Istry	
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Maryland 21215-0020	be filed ntal Hygi of other event, Be Co	17. Fathar's Nama (First, Middla,	Last)			-	18. Mothar's Nan		Melden Sumer	na)		
lar	Tabe m	Earle L.	Johnson				Alma	B. Baco	ote			
ar		19a. Intormant's Name/Ralations					at and Number or Ru		er, City or Town	, Steta, Zip C	Code)	
	12 min	Alma B. Johnso	n/Mother				10 above	T				
Baltimore,		20a. Mathod of Disposition 1 ☑ Buriel 2 ☐ Crametion	3 Danamoval from		Place of Dispo cematary, crai	osition (Nama of matory or other pi	(aca)	Data	20c. Location	- City or Tow	m, State	
ti	tant:	4 Donation 5 Othar (5	pecify)				h.Cem.3/1	Society	/ Hill	,S.C.		
Bal	permit. Pagas Department of Important: If i any injury or once.	21. Signatura of Funaral Sarvica Licensaa 22. Nama and Addrass of Facility H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Wash., D.C.										
CF -	Physician /Medical Examiner	shock, or heart teilura. List Immediate Cause (Finel diseesa or condition rasulting in daath)	Fe.	D INJURIE	S (or es a consec	quenca ot):				1 1 1 1 1 1 1 1 1 1 1 1 1	Approximata Interval Between Onset and Deeth	
ó	ate be axecuted hysteian and the burial-transit	Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disaasa or Injury	b	Dua to ((or es e consac	quance of):						
Box 68760,	ate the the	Cause (Disaasa or Injury that initieted evants rasulting in daath) Last	c	Due to (or es e consec	quence of):						
	d for d for	Part II. Other significant conditi	ons contributing to	death but not ra	sulting In the u	indarlylna causa a	ivan In Part I	23b. Did	tobacco use co	ntributa to	the cause of death?	
, P.O.	v requiras that tha death been signed by tha atta should be datached for leted by Physicia							1 🗆	Yes 212 No	3 Probe	ably 4 Unknown	
Division of Vital Records,	9 2 C							24a. Was	an autopsy ormed?	avai	ra autopsy tindings ilabla prior to npletion of cause eath?	
<u>~</u>	The late he page							11 😿	Yas 2□No	10	Yas 2□ No	
/ita	cartificata rector, pag	25. Was case referred to medical axaminar?						ath (Chack only	one)			
of	this continued and direction To	1 Yas 2 No			ER/Outpatie	nt 3LI DOA		loma 5 □ Rasi)	
u C	After funer funer	27. Mennar of Death 1 Natural 5 Pandi		a of Injury nth, Day Year)	28b. Time o	p W	uryat ork? ⊒Yes 2 [∑No		how injury occu			
Divisio	To the Hospital or Attending Physician: within 24 hours aftar death. To the Funeral Director: After this cardificomplataly filled in by the funeral director, Medical Certification: To Be	2 ☐ Accidant invast 3 ☒ Suicida 6 ☐ Could 4 ☐ Homicida datam	FOUND		FOUND:7; homa, farm, str	raat, tactory, office	^	281. Location (Y VEHICLE Streat end Num. WREAR & K R. MARYLA	beror Rural	Route Number, LAGE DRIVE	
	Hospitu 24 hours Funera lataly fille		ng Physician: To th Examinar: On the	a best of my kn			tima, data and place opinion, deeth occu	, and dua to tha	cause(s) end m	enner as sta		
	within 2 To the compla	29t. Signature and title of certific	\$ D	0		29c. Lica	nsa number		29d. Data signa	ad (Month, D	Pay, Year)	
•		▶ Wagnite	mech	ul	on		O.C.M.E.		March 1	13, 19	99	
2 -	IVa	30. Name and address of person	n p. 14	non			Street,	Baltimo	re, Mary	yland	21201	
	State Registrar	31. Dete tiled (Month, Dey, Year,		Registrer's Sign	d.	South	>					

Please Type or

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	State of N	nai yianu i		tificate c		IU IVI		g. No.	9 [18	190
. Decedent's Nema (First, Middle, Las							2. Date of Deeth Month	Dey	Yeer	3. Tin	na of Death
DORIS E.	JAMES						MARCH	1,	1999	5:	30PM
a. Facility Nema (If not institution, give	street end numbe	r)			4b. City, Town	n, or Lo	cation of Death	4c. County	of Deeth		
900 OTHMAN DRIV	Έ				Fort Wa	ashi	ngton	Prin	ce Geo	orge	es
061-24-1683	THE ME	Age (In yrs. lest 70	birthdey) Yrs.	If Under 1 Ye Months De		Hrs. Min,	8. Data of Birth (Month, Dey, 12-28-	Year)	9. Birthple Count Wash	ry)	ete or Foreig
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15. Decedent's Edu (Specify only highest grad	ication le com <i>pleted)</i>	11	6e. Deced (Give I	ent's Usuel Oc	cupetion ne during most c lired)	of working	ng 1	6b. Kind of B	usiness/Indi	ustry	
Elementery/Secondary (0-12)	Collega (1-4o	r 5+)	-		-			AL /A			
7. Father's Neme (First, Middla, Last)	2+		Pay	roll C	lerk		# 1 . 1 . 1 . 1 . 1 . 1 . 1 . 1 . 1 . 1	N/A			
, .,, .,	n In						(First, Middle, M Parrish	elden Sumer	ne)		
Joseph Wheele									-		
9a. Informent's Neme/Reletionship (T)	ype, Print)						Route Number,			Code)	
James McCoy/Son				Ithman lition (Name of		. wa	ish., Md			-	
0a. Method of Disposition 1 ☐ Burial 2XXCremetion 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)		a ceme	tery, cram	atory or other	olece) rematory	y 3/		oc. Location Riverd			0
1. Signature of Funeral Service Licens	Hack	ST.	22.		dress of Fecility anchi Fu pshur St		kett's al Serv	Funera ice	1 Char	pel,	Inc.
3a. Partt. Enter tha disaase, or comp	licetions that caus	ad the death. D	o not ente					st,		Approx	imeta Batween
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mmediete Cause (Finel	METAS	TATIC C	OL ON	CANCER						2 V6	ears
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equentially list conditions, any, leading to immediate	b	Due to (or es	e consequ	uence of):							
euse, Enter Underlying Jeuse (Diseese or Injury net initieted events esulting In death) Lest	C	Due to (or as	a consequ	ence of):							
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ert II. Other significant conditions cor	ntributing to death	but not resulting	n in the un	derlying cause	given in Part I		23b. Did tol	acco uss co	ntribute to	the car	ese of death
Bowel Obstruction							1 🗆 Ye				4 🗆 Unknov
Chronic Obstructi	ve Lung	Disease	2				24a. Was er perform	eutopsy ed?	ava	llable p	osy findings rior to of causa
								VV			
							1 ☐ Ye	s XXNo	10	Yas	2□ No
. Wes case referred to medical examiner?					28. Piece o	f Deeth	1 ∐ Ye		10	Yas	2∐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f ahow must be notified at

6 items 23a

permit. Pages 1 and 2 should be filed within 72 hours after death Department of Heelth and Mental Hyglene. Introduting filem 27 le marked other than "natural", or items 23, any injury or other treumatic avent, the Mende

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

Be

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the Meryland

Physician/Medical Be Completed by Certification: To

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit on the page 2 should be detached for use as the buriel-transit Medical

Division of Vital Records, P.O. Box 68760,

0

State Registrar

31. Dete filed (Month, Dey, Year) MAR 0 5 1999

1X Neturel

2 Accident 3 Suicide

4 Homicide

Signature

29a. Certifian

29b

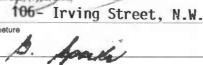
John E. McKnight, M.D.

5 Pending Investigation

8 Could not be determined

32 Registrer's Signeture

as of person who completed cause of death (Item 23a) (Type, Brint)



28a. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 Yes 2 No

DC 15185

Certifying Physician: To the best of my knowledge, deeth occurred the time, dete end plece, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of exeminetion and/or investigetion, in my opinion, death occurred et the time, dete and place, and dua to the cause(s) end menner stated.

28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

3-3-99

29d. Date signed (Month, Day, Year)

ATT CORAN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death

				Certif	ficate	of De	eath			Reg. No.		0131					
	1. Decedent's Name (First, Middle, L								2. Data of De	ath Day	Year	3. Tima of Death					
Physician /Medical	THELMA R.	THELMA R. JOHNSON March 1, 1999										11:32 PM					
Examiner	4a Facility Name (If not institution, g					4b.	City, Tov		cation of Death	4c. County	of Death						
	Mariner Health						lin			Princ		corge's					
Funeral Director	579-26-7871	Sex 7. Ag	ge (In yrs. last b		f Under 1 Y Nonths D		Hours	Min.	8. Date of Bird (Month, Da 8/24/2	h y, Year) 22	9. Birthp Cour Salt	place (Stata or Foraign etry) uda , S.C.					
Du Bar	Usual Residence of Decedent 10s. State 10b. County		10c. City, Toy	n or Locati	ion						1	0d. Inside City Limits					
with the Meryland a or 28a-f show be notified at	Md. P.G.			itol	Heigh							XX Yes 2 No					
th with th	10e. Street and Number 7010 Independ	lence St.			10f. Zip Co 2074					10g. Citizen of What Country? U.S.A.							
within 72 hours effect deeth v within 72 hours effect deeth v han "natural", or frame 23a han dical Examinar must manifect by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 223 If Yes, Give Year or Dates:			a Decedent es, specify Yes		enic Orig Mexican Specify:	jin? (Spe , Puerto I	cify Yes or No Rican, etc.)	14. Rad Bla Specif	ck, White,	etc.					
72 ho	15. Decedent's I		16a		t's Usual O			of workin	20	16b. Kind of B	usiness/In	American Indian, White, etc. Black ness/Industry Home tate, Zip Code) ity or Town, Stata or, Md. 20019 Approximate interval Between Onset and Death VESS ributa to the cause of death? Bl Probably 4 Junknown					
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Mentel H fill Mentel H Mentel H Mentel H Mentel Ott	George Miles							Sop	hia You	ing							
A PER	19a. Informant'a Name/Relationship (Type, Print) Hazel Langford/Daughter 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State Same as # 10 above									, State, Zip	Code)						
SSITIMOTE, M Demit. Pages 1 and 2 Department of Heelth of Important: if Nem 27 is eny injury or other tra	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			ry, cremate	on (Name of one of or other	r place)		3/6	Date /99	20c. Location							
Caltil pemit. P Depertment importer eny injur	21. Signature of Funeral Service Licensee 22. Name and Address of Facility H. S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N. E., Wash., D. C. 20019																
	23a. Part1. Enter the disease, or cor	mplications that cause	d the death. Do	•							C. 20						
Physician /Medical Examiner	shock, or heart failure. List onling in the condition resulting in death)	79	10 - ST			vec	<u> </u>	ISE	ASE		1	Onset and Death					
death certificate be executed extraording physician end ad for use as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as a														
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permit. Pages 1 and 2 should be filed within 7 Department of Health end Mentel Hygiene. Important: If Itam 27 is marked other than "n any injury or other traumatic event, the Med once.

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by Funeral 1 ☐ Never Merried 2 ☐ Merried 3 □ Widowed 4 □ Divorcad Completed Elementery/Secondary (0-12) 12TH GRADE 17. Fether's Neme (First, Middle, Last) WILLIAM LEWIS SMITH 19e. Intorment's Neme/Reletionship (Type, Print) RICHARD C. HILL 20e. Method ot Disposition 1 Buriel 2 Cremetion 3 Removel from Stete 4 □ Donetion 5 □ Other (Specify) Immediete Ceuse (Finel diseese or condition resulting In deeth) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Last Physician/Medical Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. by 24b. Were eutopsy tindings evallable prior to completion of cause of deeth? 24e. Wes en autopsy performed? Completed 1 ☐ Yes 2 ☐ No mo 25. Wes case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury Certification: 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Netural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28t. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner steted. 29a. Certifier Medica (Check only 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) ted cause of death (Item 23e) (Type, Print)-

Registrar **DHMH 16 Rev 6/95**

30. Name and address of person who con

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e a little - Jan Saylan

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Natalie Joseph 0300 A 17,1999 February /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center 5. Social Security Number 6. Sex 7. Ann 1/11 was less to Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 22, 1965 Birthplace (State or Foreign Country) **Funeral** 1□M 2/2 F Months Days Hours Min. Yrs. 578-02-7690 33 May Director France Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits Takoma Park Md. Montgomery Yes 2 No Director 28a-f 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20912 7710 Maple Ave. #305 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1€ Never Married 2 Married 1 ☐ Yes 2/ No If Yes, Give Year or Detes: 1 Yes 3 No Specify: Black Specify: ð 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry a flad within 7 at Hyglens. d other than " College (1-4or 5+) Elementary/Secondary (0-12) Human Resourses Devel. Spec. Peace Corp 5+ permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important if flem 27 is marked othe any injury or other traumatic event, policie. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anita Fitzrov G. Joseph Mayo 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fitzroy G.Joseph 1007 Devere Drive Silver Spring, Md. 20903 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State 2/25 4 Donation 5 Other (Specify) Harmony Memorial Park Landover, Md. 22. Name and Address of Facility Hunt Funeral Home 21. Signature of Funerel Service Licenses 908 Kennedy St.N.W.Wash.D.C.20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Non - Hodakins Ly
Due to (or as a consequence of) Lymphoma Examiner Physician/Medical Examiner Lungemia physician and the buriel-transit Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Systemic Lupus Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Ď 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate has b 1 No Yes 2 No 1 Tyes 2FUNo 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 123Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 BNaturat 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 6 4 ☐ Homicide

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Name 23s

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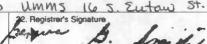
efter deeth Director:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elizabeth Stoller, mo State

31. Date filed (Month, Day, Year) MAR 0 1 1999

(Check only one)

29b. Signature and title of certified



mo

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

P10024

29d. Date signed (Month, Day, Year)

17, 1999

February

Battimore, MD 21201

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Rosa Johnson 27 . 1999 4c. County of Death Feb /Medical 6:42 PM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner Holy Cross Hospital Spring
8. Date of Birth
(Month, Dey, Year) Silver If Under 24 Hrs. Montgomery

9. Binhplace (State or Foreign Country) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** 1□M XXF Months Days Hours Min 578-42-2957 Yrs. 1901 Sept, New York Director 98 Usual Residence of Decedent the Merylend 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show soldal Examiner must be notified at DC Washington 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with 1401 Sheridan St. NW USA 20011 Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22000 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 should be filed within 72 hours efter of and Mental Hygiene. Is marked other than "natural", or flea aurnatic event, the Mexical Examinations. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4X Novorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) Stenographer Federal Government 12 permit. Pages 1 and 2 should be filled.
Department of Heelth and Mental Hyginimportant: If them 27 is marked other any injury or other traumests. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Harry Ableman Mollie Frender 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pnint) Maurice A. LaPlace/Nephew 2700 Riding Dr. Wilmington, DE 19808 20a. Method of Disposition

20a. Method of Disposition

3 □ Removal from State 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Fairview, Mt. Moriah 3/4/99 New Jersey 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Takoma Funeral Home 21. Signature of page Service Licensee 254 Carroll St. Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or hear feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Pneumonia disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Respiratory failure
Due to (or as a consequence of): physician end s the buriel-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Due to (or as a consequence of): signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. P.0. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? should Completed 24a. Was an autopsy i certificate hes l 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: XXInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Yes 2 No thin 24 hours efter death. the Funeral Director: Ampletely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the Vithin 2 To the Complet 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Feb. 27, 1999 D0052255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raul Passi, MD 1500 Forest Glen Rd., Silver Spring, MD 20910 31. Date filed (Month, Day, Year)
MAR 0 2 1999 32 Registrar's Signature State Registrar back

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month arch. Norman Garrett JAMISON 4c. County of Death 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Washington County Hospital Washington Hagerstown If Under 1 Year 6. Sex 1 ₩ M 2 ☐ F If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months 80 June 27 1918 Maryland 216-14-5260 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Washington Sharpsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 116 E. Antietam Street 21782 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ②No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Plastic and vinyl Elementery/Secondary (0-12) Coilege (1-4or 5+) 6 0 Products Maintenance 17. Father's Neme (First, Middle, Last) 18. Mother's Name /First. Middle Maiden Sumame Harry Peyton Martha Jamison 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma J. Jones - Daughter 416 N. Jonathan Street Hagerstown, Md. 21740 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/4/99 Hagerstown, Maryland Hagerstown Crematory 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Ceuse (Finel SEPTICEMIA DAYS diseese or condition resulting in death) Due to (or as e consequence of): URINARY TRACT INFECTION , week week Due to (or es a consequence of) HYDRATION weeks 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Invascular accident 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2000 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

rai", or items 23a or 28a-f ahow Examiner outst be notified at

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permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: if them 27 le marked other
eny Injury or other traument.

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Saltimore, Maryland 21215-0020

Director

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Examiner Box 68760. Physician/Medical USB Jan; son, Norman Division of Vital Records, P.O. signed by t by Completed Be edical Certification: To 24 hours efter deat Funeral Director:

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 255 No 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No 2□ Accident investigation 6 ☐ Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier

State Registrar (Check only one)

29b. Signeture end title of certifier

31. Dete filed (Month, Day, Year)

MALIK

MAR 0 5 1999

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

2APAR MAUK MD 203/1 LAPPAN'S RD 20311 32. Registrer's Signeture

29c. License number

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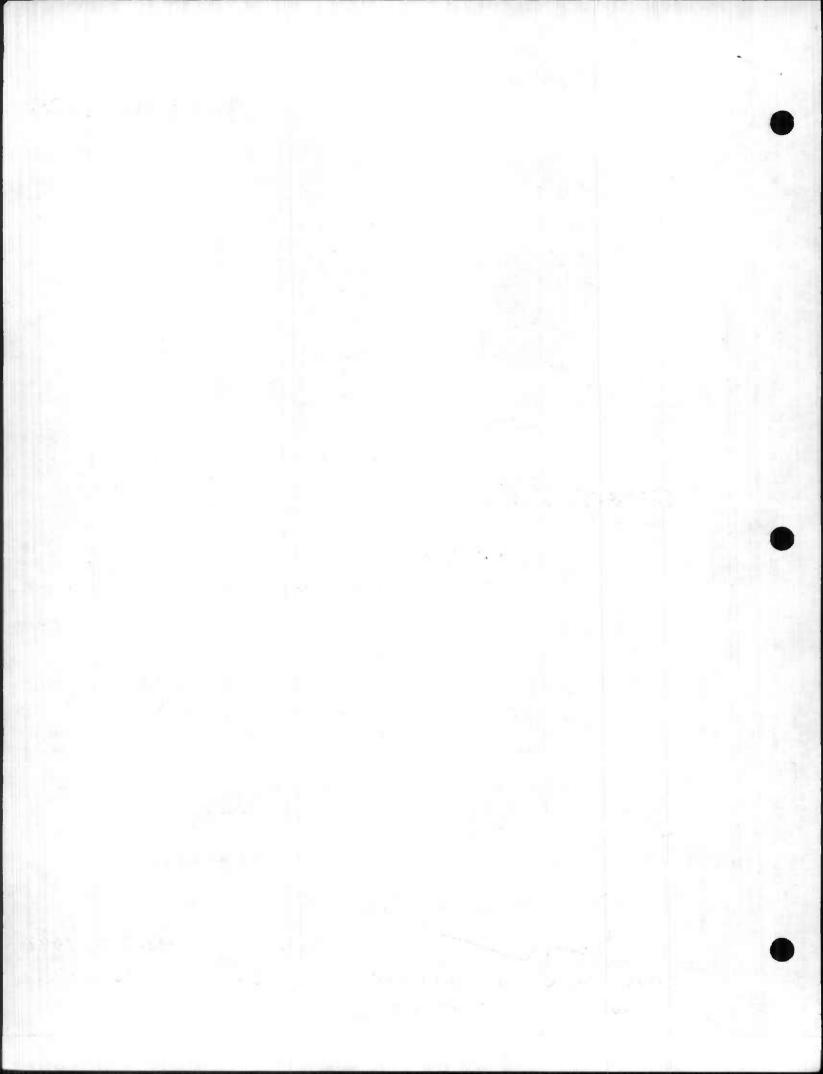
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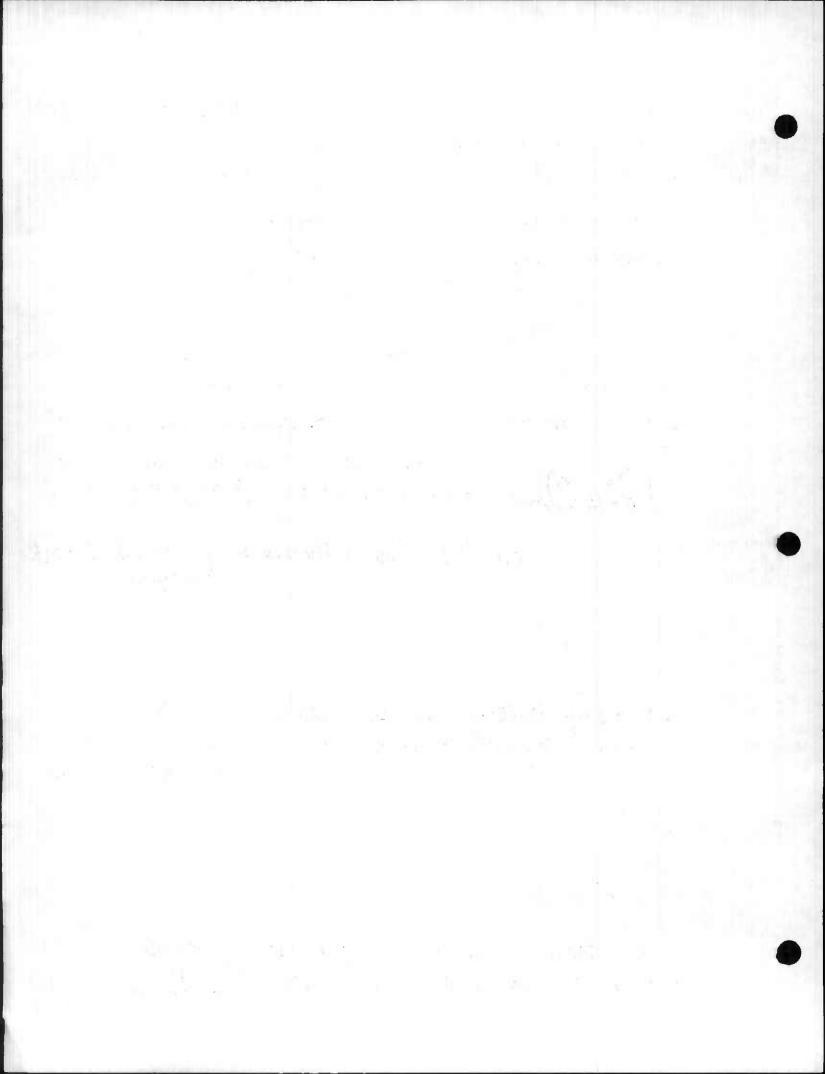


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** :30 AM MAYNARD LEE **JONES** /Medicai 4a. Fecility Nama (If not institution, give streat and number) 4b. City, Town, or Location of Daath **Examiner** WESTERN MARYLAND HOSPITAL CENTER HAGERSTOWN WASHINGTON If Undar 1 Year If Under 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, Year) JULY 12, 1913 5. Social Sacurity Numbar 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funerai** Days 1 1 M 2 F Yrs Director 214-16-0776 MARYLAND Usual Rasidanca of Decedant 10a, Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show traumatic event, the Madical Examiner must be notified at 1X Yas 2 No Director MARYLAND BOONSBORO WASHINGTON 10e. Straat end Number 10f. Zip Coda 10g. Citizan of What Country? 6 230 332 NORTH MAIN STREET 21713 2 should be filed within 72 hours after death on and Mental Hyglene.
Is marked other than "natural", or items 23s U.S.A. Funerai 12. Was Decedent Ever in U,S. Armad Forcas? 13. Was Dacedant of Hispanic Orlgin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - American Indian, Black, White, atc. 1⊠Yas 2□No 1941− If Yas, Giva Year or Datas: 1945 1 Never Married 2 ☐ Marriad Baltimore, Maryland 21215-0020 1 Yas 2X No by Specify 3 ☐ Widowed 4 🖾 Divorced WHITE Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) OPERATOR/LABORER CEMENT MANUFACTURING 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumama) JOHN H. JONES 10 IRENE MAE MONGAN 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any Injury or other traum once. ROBERT E. EASTERDAY/NEPHEW 5726 MT. CARMEL CHURCH ROAD, BOONSBORO, MD 21713 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 X Buriel 2 ☐ Cramation 3 ☐ Removel from Stata 4 ☐ Donation 5 ☐ Other (Specify) 3/12/99 BOONSBORO, MARYLAND MANOR CEMETERY 22. Nama and Addrass of Facility 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 Perf. Enter the disease, & complications that caused the death. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immadiate Cause (Final disaasa or condition rasulting in death) /Medical Examiner Physician/Medical Examiner Sequantially list conditions, if any, leeding to immadiata causa. Entar Underlying Cause (Diseasa or injury thet initiated avants rasulting in daath) Last pue Dua to (or as a consequence of): attending physician e for use es the burial-Box 68760, Dua to (or es e consequance of) Part il. Other eignificant conditione contributing to daath but not rasulting in tha undarlying causa givan in Part i. Division of Vital Records, P.O. the 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 □ Unknown þ 24b. Wara autopsy findings evallabla prior to complation of cause of death? Completed 24a. Was an autopsy performed? hes 1 Yas 2 No 1 Yas certificate Be 25. Was cese referred to medical axaminar? 26. Place of Deeth (Check only ona) Hospital: 1 Inpatient 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To After this 27. Menner of Death 1 Natural 28b. Tima of 28d. Dascribe how injury occurred Hospital or Attending 5 Pending invastigation the Funeral Director: After and filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Steta) 4 Homicida Cartifying Physician: To the best of my knowladga, deeth occurred at tha tima, data and plece, and dua to tha causa(s) and manner as stated.

2 Madical Exeminar: On the basis of axamination and/or investigation, in my opinion, death occurred at the tima, data and place, and due to the ceusa(s) and manner stated. Medical 29a. Certifiar (Check only one) To the within 2 29b. Signature and titla of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) se of death (Itam 23a) (Type, Print) Western 30. Name and address of person 31. Data filed (Month. Day. Yaar) 32. Ragistrar's Signatura State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Data of Death 1. Decedant's Nama (First, Middla, Last) 3. Time of Death Month **Physician** Jeannette Katharina JOHNSON 1999 7:10 p.m. March /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Homewood Retirement Center Williamsport Washington If Undar 1 Yaar If Undar 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 8. Data of Birth (Month, Day, Year) **Funeral** 1□ M 2ਊ F Yrs. Director 309-58-1698 99 Ohio Usual Rasidance of Dacedant 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 1 Yas 2 No Director Maryland Washington Williamsport 10e. Street and Number 10g. Citizan of What Country? 16505 Virginia Avenue Funeral 21795 U.S.A. 12. Was Dacedant Evar in U,S. Armed Forcas?

1 Yas, 2 No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yas 2 X No Specify: Specify: White à 3 Ø Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry filed within Hygiene. ther than Eiamantary/Secondary (0-12) Collaga (1-4or 5+) permit. Peges 1 end 2 should be filed w Depertment of Health end Mertel Hygien Important: If Item 27 is marked other the any injury or other traument 12 Homemaker Her own home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be David Begel Louisa Klugman 19a. informant's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19714 Scott Hill Drive Hagerstown, Md. 21742
of Disposition (Nama of Data 20c. Location - City or Town, State James Johnson, Jr. -Grandson 20b. Placa of Disposition (Nama of cematary, crematory or othar placa) 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 3/13/99 Cass County, Indiana 4 ☐ Donation 5 ☐ Othar (Specify) Everrest Memorial Park 21. Signature of Funarai Sarvice Licensee 22. Nama and Addrass of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 Vestel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximata intervei Between Onsat and Death **Physician** /Medicai Immediete Ceusa (Final disaasa or condition rasulting in daath) Examiner Sequantially list conditions, if any, laading to immadiata causa. Entar Undarfying Cause (Disaase or Injury that initieled evants resulting in death) Last EMETUTA Physician/Medicai Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown 1007H4NO (1)55 ģ 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? his certificate has b 1 ☐ Yas 2 ☐ No 1 Yas 2 No this certificate or Attending Physician: Be 25. Was casa rafarred to medical 28. Piaca of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 | Yas 2 | No 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred Medical Certification: After 1 Stetural 5 Pending invastigation 1 Yas 2 No 2 Accidant Director: 3 Suicida 6 Could not be To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by the 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28a. Plece of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end mannar as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifian 29b. Signatuse a 29c. Licensa number 29d. Data signed (Month, Day, Year) WEER

ted causa of death (Itam 23a) (Type, Print)

ZNO

32. Registrar's Signatura

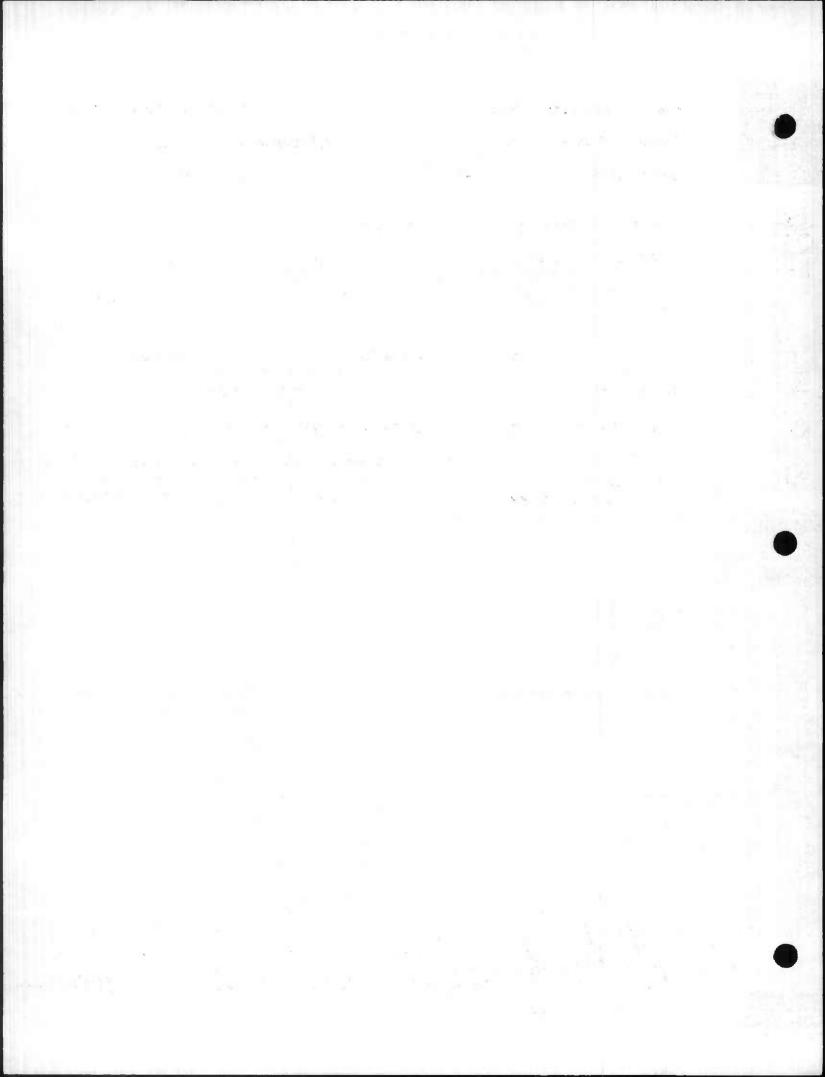
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31. Data filed (Month, Day, Year)

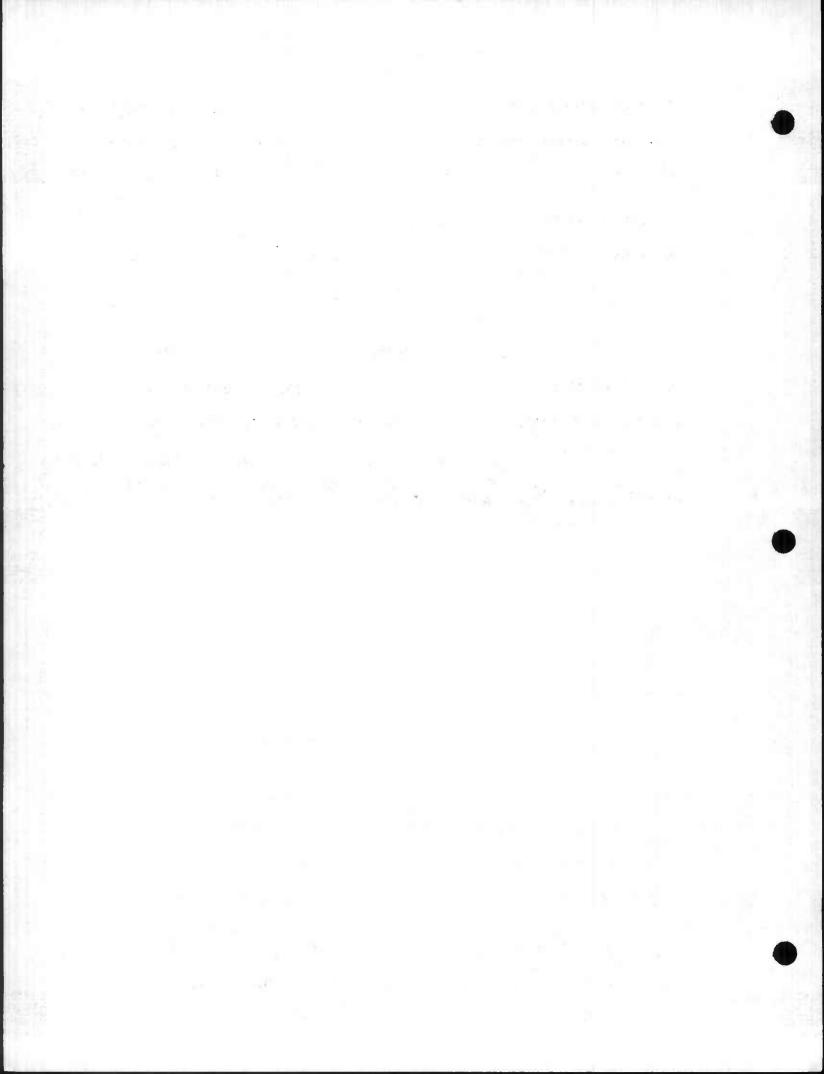
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State of Maryland / Department of Health and Mental Hygiene 9 08798

				Ce	rtificate e	of Death		Reg. No.	0.0	1 20	
Dhusia	ion	1. Decedent'a Name (First, Middia, Last,					2. Date of De Month	ath Day	Year	3. Time of Death	
Physic /Medi		HELEN MARGARETTA	KERSCH				03	05 19	799	1342	
Exami		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	r Location of Death	4c. County	of Death		
		DORCHESTER GENERA	L HOSPITAL			CAMBRIDG		DORCH	ESTER		
Funeral Director		215-09-1648	7. Aga (In)	rs. last birthday Yrs.		aar If Under 24 Hr ays Hours Mir	1. (Month, Da	h y, <i>Year</i>) 22,1917	Countr		
pue *		Usual Residence of Decedant 10a. State 10b. County	10c.	City, Town or L	ocation				10	d. Insida City Limits	
the Maryland 28a-f show	Director	MARYLAND DORCHEST		IURLOCK		manufactures, and a			1X Yas 2□N		
23a or 2		10e. Street and Number 403 WRIGHTS AVENUE				1643			What Countr	ry?	
d 2 should be filed within 72 hours efter death with the Maryler hand Mental Hyglene. T is marked other than "natural", or items 23s or 28s-f show traumstic event, the Modical Examiner must be notified as	by Funeral	11. Marital Statua 1 □ Never Married 2 □ Married 3 □ Wildowad 4 □ Divorced	12. Waa Decedent Evar II Armed Forces? 1 ☐ Yas 2 ② No If Yes, Giva Yaar or Dates:	n U,S. 13.	Waa Decedent It Yas, specify (1 ☐ Yes 2 🗓	of Hispanic Origin? (Cuban, Maxican, Pue No Specify:	Specify Yes or No nto Rican, atc.)	Specify	ce - Amarica ck, White, at WHI	tc.	
hin 72 hc	Completed	15. Decedent's Edu (Specify only highast grad	cation	16a. Dece	edent's Usual Oc	ccupation	orkina	16b. Kind of B	usiness/Indu	ustry	
within ene. then	du	Elemantary/Secondary (0-12)	College (1-4or 5+)			one during most of wo tired)	J. T. T. T. T. T. T. T. T. T. T. T. T. T.				
filled wit Hygiene ther the			2	BOOKE	KEEPER	1		RETAIL STORE			
be file tal Hyg d othe event,	Be	17. Father'a Name (First, Middle, Last)				18. Mother'a Na	ame (First, Middle,	Maiden Suman	10)		
should be nd Mental marked o	2	JAMES AGNEW WILSON					E AGNES 1				
d 2 should th and Mer 7 is merks traumatic		19a. Intormant's Name/Relationship (Ty				reet and Number or F					
		DOTTIE ANDREWS/FRI				CREEK ROA					
8522		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval nom Stata		oaition (Nama o amatory or othar GE CREMA		3/7/99	20c. Location -			
parmit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Ligens	12/1	1 3	Nama and Ad ELLER F	ddress of Facility UNERAL HON	ME, P. O.	BOX 20)7,		
Physician /Medical Examiner		23a Party Enter the disease, or complete shock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	Acute	EWfe	estimate mode of	STREET, I	ac or respiratory a	rest,		Approximate Interval Between Onset and Death	
	-	INVESTIGATION IN		o (or as a conse	equence ot):				i	2111	
petro pus pus pus pus pus pus pus pus pus pus	Examiner	Sequentially list conditions	Septie Due to	o (or as a conse	guence of).					oghy	
an ar		Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or Injury		(0,10,00	4				i		
leth certificate be emoured strending physician and for use as the buriel-fransit	n/Medical	Cause (Disease or Injury that Initiated events reaulting In death) Last		o (or as a consa	quanca of):						
deeth ce e ettendii od for use	icia	Part It. Other significant conditions con	telbuting to dooth but not	roculting in the	andred day agus	ahras la Dad I	ash Did	lahana was sa		the cause of death	
hat the d by th	/ Physician/	Debelitorte I	3 Frito	resulting in that	underlying cause	given in Part I.	1 🗆			ably 4 ☐ Unknow	
lew requires that as been signed b	Completed by	Type 2 Din	Jet3					an autopsy med?	svali	re autopsy tindings llabla prior to apletion of cause eath?	
0 - 0	E	H+ perfusi	an				101	es 2 No	10	Yas Davo	
iclen: Th certificate rector, par	Be	25. Was case referred to medical		-		28. Place of De	eath (Check only o	ne)	1		
	To	examiner?	lospitel:	□ ER/Outpatie	nt 3 DOA	Other: 4 Nursing	Home 5 ☐ Resid	ience 8 □Oth	er (Specify))	
After fune		27. Manner of Death 1. Natural 5 Pending 2 Accident Investigation	28a. Data ot injury (Month, Day Year	28b. Time of Injury		njury at Work? 1 □ Yes 2 □ No		now injury occur			
Die of	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, tarm, at acify)	treet, tactory, off	ice	28f. Location (S City or Tov	Street and Numb vn, State)	per or Rural i	Route Number,	
the Hospital hin 24 hours the Funeral npletely filled	edical	29a. Certifier (Check only one) 1 Certifying Physical Certifying Certifying Physical Certifying Physical Certifier (Check only one)	itcian: To the best of my iner: On the basis of exam and mannar stated.	knowledge, deat ination and/or Ir	th occurred at the	e time, date and plac ny opinion, death occ	ce, and due to the curred at the time,	cause(s) and ma date and place,	anner as sta and due to t	ited. the causa(s)	
Within To the	M	29b. Signatura and titla of cert line		29d. Data signe	d (Month, D	lay, Year)					
->-0		· my falle	ens			2638	8	3-5	99		
		30. Name and address of person who co MICHAEL J. FADDEN,	mpleted cause of death (I 302 COLLINS			CK, MARYL	AND 2164	3			
Sta	ate	31. Date tiled (Month, Day, Year)	32. Registrar's SI		9 %	a. V. 1					



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MARCH 5,1999 KANE 8:20 PM MARION JANE 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street and number) 4c. County of Deeth Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 10 M 20 F Months Deys Hours 8.6in Yrs. 80 577-48-5346 Dec. 26,1918 Pennsylvania Usuel Rasidence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Prince George's Maryland Accokeek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15601 Livingston Road 20607 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 Ø No If Yas, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced White 16a. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own home 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Floyd Wayne Allen Anna Carpenter 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Thomas M. Kane/Son 1018 Ivy Lane, Waldorf, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Data 20c. Location - City or Town, Stete 1 Durial 2 Cremetion 3 Removal from Trini# Memorial Gardens 03-10-1999 Waldorf, Maryland 4 ☐ Donetion 5 ☐ Othar (Specify) Name and Address of Fecility The Huntt Funeral Home, Inc. 21. Signeture of Funeral Service Licenses MO1695 DAVID A. GOFF P.O. Box 156, Waldorf, Maryland 20604 23a. Pert1. Enter the diseasa, or complications thet the mode of dying, such as cardiec or respiretory arrest, shock, or haert failure. List only one cause on a a mine. Approximete Interval Batween Onset and Deeth Immediate Ceuse (Final disease or condition rasulting In daeth) METASTATIC CARCINOMA IMONTH Due to (or as e consequance ot) NON-SMALL CELL LUNG CANCER 1 MONTH Due to (or es e consaguença of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No DIABETES MELLITUS 24b. Were eutopsy findings aveilable prior to 24a. Wes en eutopsy HUPERTENSION completion of cause of deeth? 2 X No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

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I or Attending after death. Director: Aft

To the Hospital or within 24 hours at To the Funeral D

Box 68760.

Division of Vital Records, P.O.

permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is in any Injury or other traun 3 once.

Physician

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s 1 and 2 should be filed within 72 hours aftar deeth with the Marylen of Health and Mental Hygiens after 23 or 28e-f show firm 27 is marked other than "natural; or items 23 or 28e-f show other traumitic event, it is listed in Examinat must be notified as

Baltimore, Maryland 21215-0020

Sequantielly list conditions, if eny, leeding to Immediate ceuse. Entar Underlying Causa (Disaasa or Injury thet initieted events resulting in deeth) Lest

26. Pleca of Daath (Check only one)

25. Wes cese referred to medicel examiner? Hospital: 1 Yes 2 No 27. Mannar of Daath 5 Panding investigation 1 Naturel

1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Dev Year)

28b. Time of

28e. Plece of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28c. Injury et Work? 1 ☐ Yas 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rurel Route Number, City or Town, Stata)

29a. Cartifier (Check only one)

2 Accident

4 - Homicide

3 Suicide

The Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signeture and title of certifier your chand

6 ☐ Could not be detarmined

29c. License number 50653 29d. Date signed (Month, Dey, Year)

30. Nama end addrass of person who completed ceuse of deeth (Item 23a) (Type, Print)

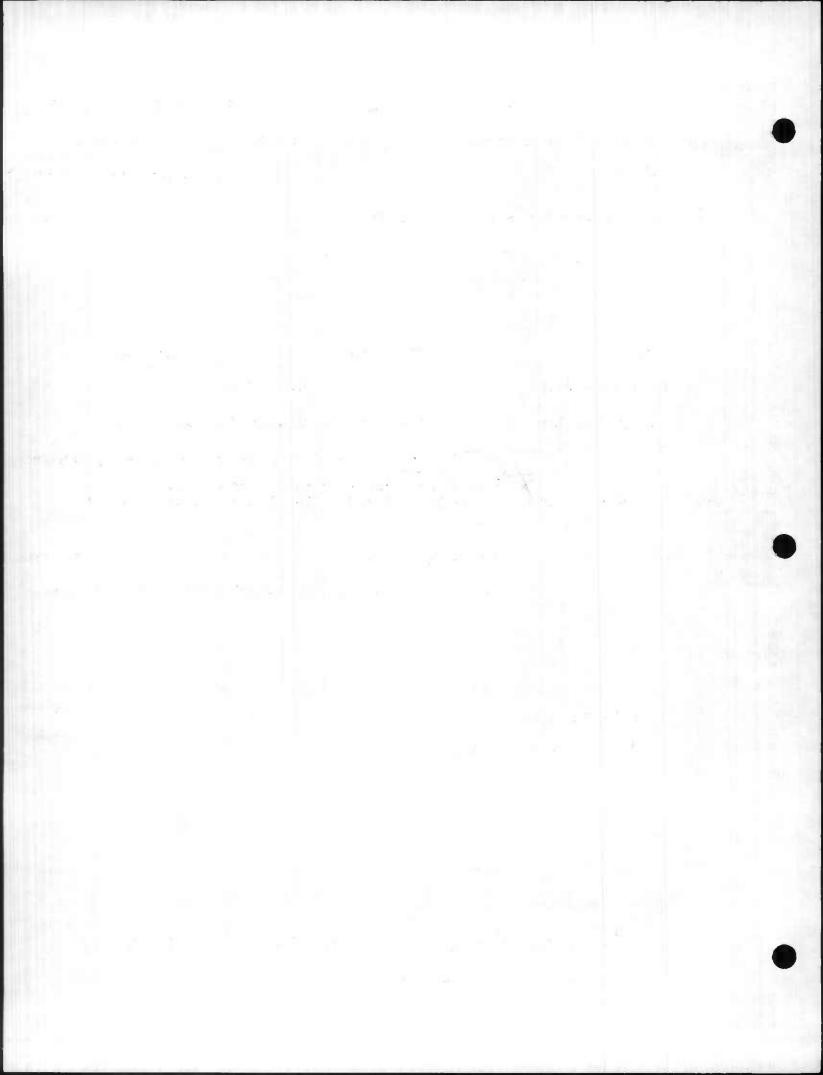
7501 SURRATTS ROAD CLINTON M.D GYAN CHAND SURANA 31. Date filed (Month, Day, Year)

State Registrar

1999 MAR 09

32. Registrer's Signeture

may a



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death Month **Physician** February 28, 1999 William John Kunz 3:00 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner St. Mary's Hospital St. Mary's Leonardtown If Undar 1 Yaar | If Undar 24 Hrs. Birthplace (Steta or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Data of Birth (Month, Dev. Year) **Funeral** Months Days Hours 1 M 2 □ F 81 Director 121-07-5310 December 12, 1917 New York Usual Residence of Decedent the Meryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner, must be notified at 1 TYes 2 No Director Maryland St. Mary's California 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 44093 Granite Way 20619 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amaricen Indian, Black, White, atc. 11 Marital Status Was Decedant Ever in U,S. Armed Forces? Peges 1 and 2 should be filed within 72 hours efter nent of Health end Mental thygiene. In the file of the than "natural", or its not file of the transfed other than "natural", or the transfes avent, the Medical Enamina 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify à White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Business Executive Aerospace 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be William John Kunz Irma Fink 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat end Number or Rurel Route Number, City or Town, State, Zip Code) 44093 Granite Way, California, Maryland 20619 Barbara J. Kunz, Wife 20b. Place of Disposition (Neme of 20a. Method of Disposition 20c. Location - City or Town, State cametery, crematory or other piece) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata permit. Pege Department of Important: If any injury or 3/1/99 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 21. Signature of Flyneral Service License 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00857 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter se disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on plach line. Approximate Interval Between Onset and Death **Physician** Metastric carcinoma of lung dical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initieled events rasulting In deeth) Last 12 months and Due to (or as a consequenca of): buriel-trar certificate be exe P.O. Box 68760. physician Physician/Medical the Dua to (or as a consequence of) USe Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by Congestive Heart Foilure 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of deeth? a trid Fibrillapor 24a. Was an autopsy Completed page 2 1□ Yes 2₽No 1 ☐ Yes 2 ☐ No certificete Division of Vital Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this funeral 27, Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of After Attending 5 Pending invastigation 1 Natural Mospital or Attending
 24 hours efter deeth.
 Funeral Director: After 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred of the fime, date end piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Data signed (Month, Dey, Yeer) D36206 3/2/99 Kometh 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) HOII7 WOLD MD 20636 mehto KIVON-

DHMH 16 Rev 6/95

State

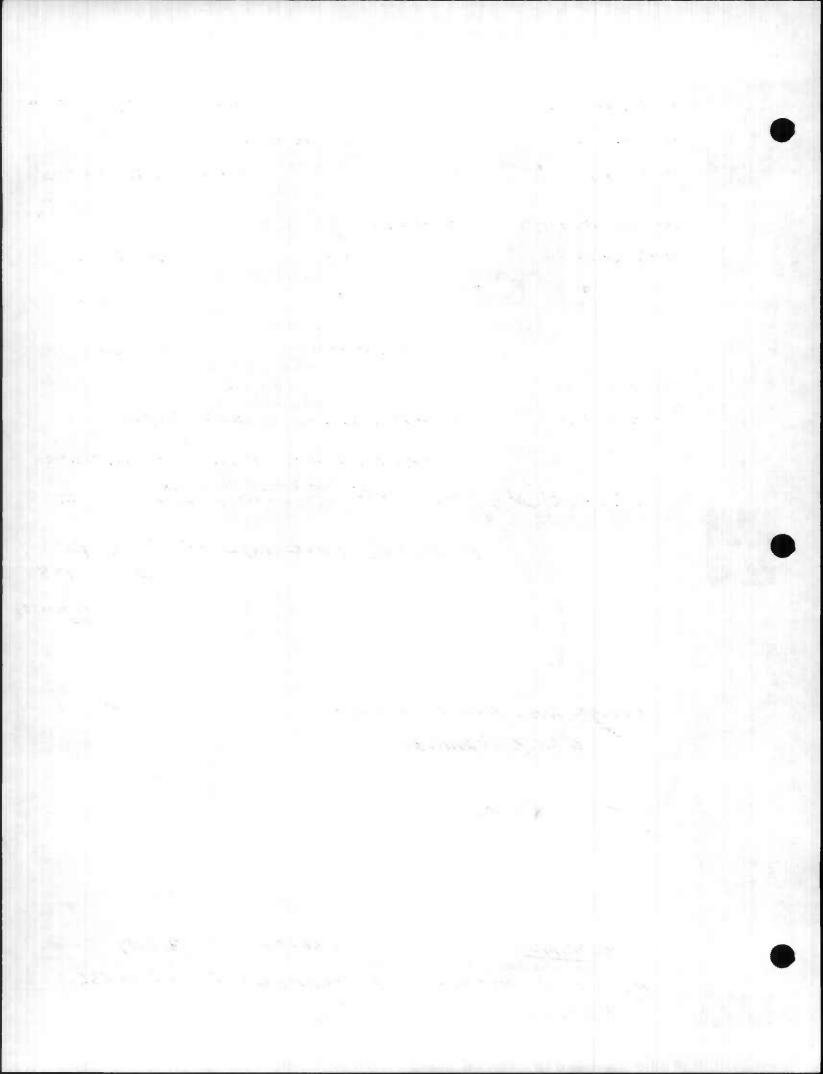
Registrar

31. Date filed (Month, Day, Year)

MAR 03 1999

32. Registrar's Signature

General



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month **Physician** 3, 1999 th 4c. County of Death J. Stephen 12:40 AM Kurtz March /Medical 4b. City, Town, or Location of Deeths 4a Facility Name (If not institution, give street end number) Examiner 13660 Ryceville Road Mechanicsville Charles If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Deys Hours 10XM 20 F 78 Yrs. 214-58-0132 Director 6,1920 Pennsylvania Usual Residence of Decedent the Marylend 10a. State 10c. City. Town or Location 10d. Instde City Limits 10b. County "natural", or items 23a or 28a-f show 1 ☐ Yes 2 🗓 No Charles Maryland Mechanicsville Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 13660 Ryceville Road 20659 U.S.A.

14. Race - American Indian, d 2 should be filed within 72 hours after death the and Mentel Hygiene.
7 Is marked other than "natural", or items 23, fraumatic event, the Medical Experies must Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus Black, White, etc. 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 Yas 2 No Specify Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usuel Occupation
(Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Etamantary/Secondary (0-12) Collega (1-4or 5+) Furniture Maker Self 8th permit. Pages 1 and 2 should be file Department of Health and Mentel Hyy Important: if Item 27 is marked othe any Injury or other traumatic event, bDbb. 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maidan Sumeme) Joseph Kurtz Fannie Byler 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20659 Gideon S. Kurtz/Son 28000 Briscoe Anderson Lane, Mechanicsville, MD 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, State 1 X Buriel 2 Cremation 3 Removel from State 3/5/99 4 ☐ Donation 5 ☐ Other (Specify) Hertzler Cemetery Mechanicsville, MD 22. Name end Address of Facility
Mattingley-Gardiner Funeral Home, P.A. 21. Signeture of Funeral Service Licensee 23a. Pert1. Enter tha disaasa or complications that ceusad tha beath. Do not entar the mode of dying, such as cardiac or respiretory errest, shock, or heart failura. Liat only one cause on each line. P.O.Box 270, Leonardtown, MD 20650 Approximate Interval Between Onset and Death **Physician** Immediata Causa (Final disease or condition rasulting In daeth) Metostatic Lung Canidoma /Medical 6 MANTE Examine Examiner physician and the burief-transit The law requires that the deeth certificate be executed Saquentiatly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Dua to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): for use as signed by the e Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. CHOME Obstrette pelmony 3☐ robably 4☐ Unknown 1 Yes 2 No à 24b. Ware autopsy findings evailable prior to 24a. Was an eutopsy performed? Completed completion of cause of daath? congestive heart Failar i certificete has b 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: after death. Director: After this certifice 25. Was casa raferrad to madical examiner? 26. Placa of Deeth (Check only ona) Be Hospital: 1 ☐ Inpatlant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Aasidence 6 ☐ Other (Specify) 1 Yas 2 No 2 28a. Date of Injury (Month, Dey Year) 27. Mannar of Daath 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurrad Certification: 1- Natural 5 Panding invastigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 | Homicide To the Hospital or within 24 hours aft To the Funeral Discompletely filled in 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end place, and dua to tha causa(s) end menner as stated. edical (Check only one) 2 Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner stated.

29c. License number

026206

pollywood A1) 20636

29d. Dete signed (Month, Dey, Year)

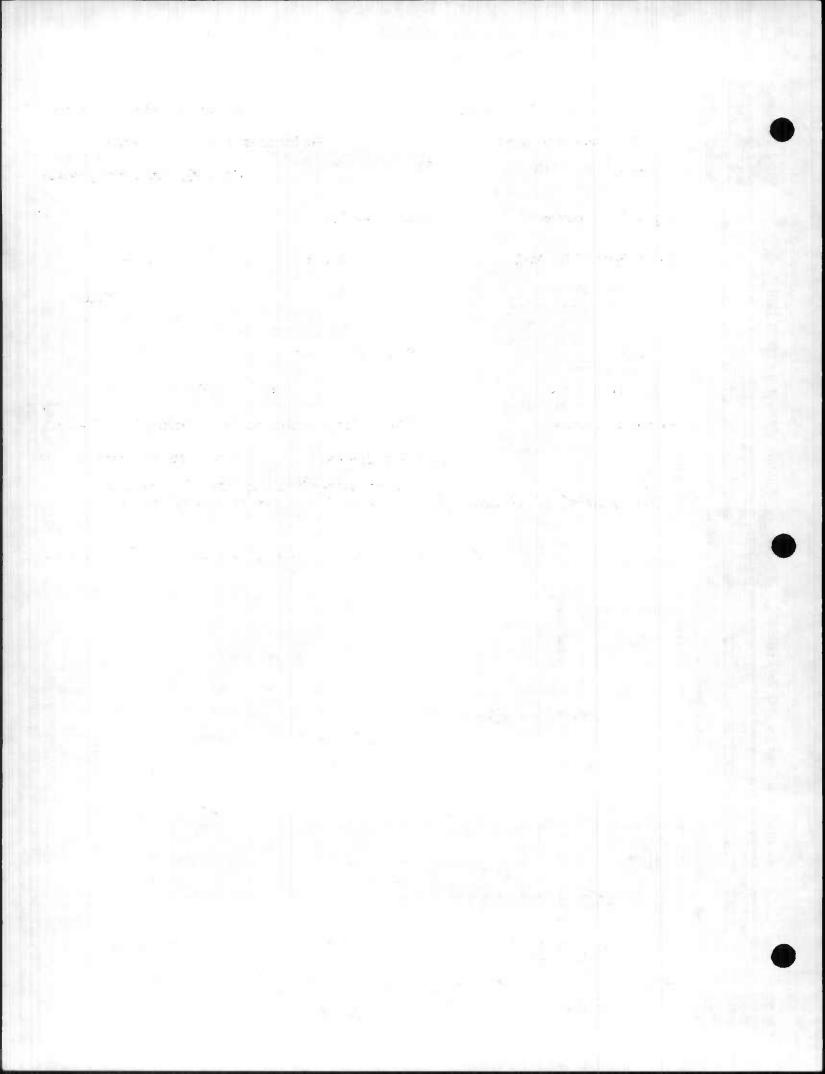
Registrar

29b. Signeture end title of certifier

romeril

30. Nama and addrass of person who completed ceuse of death (Item 23a) (Type, Print) Mexta mi

32. Redistrar's Signature



Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q

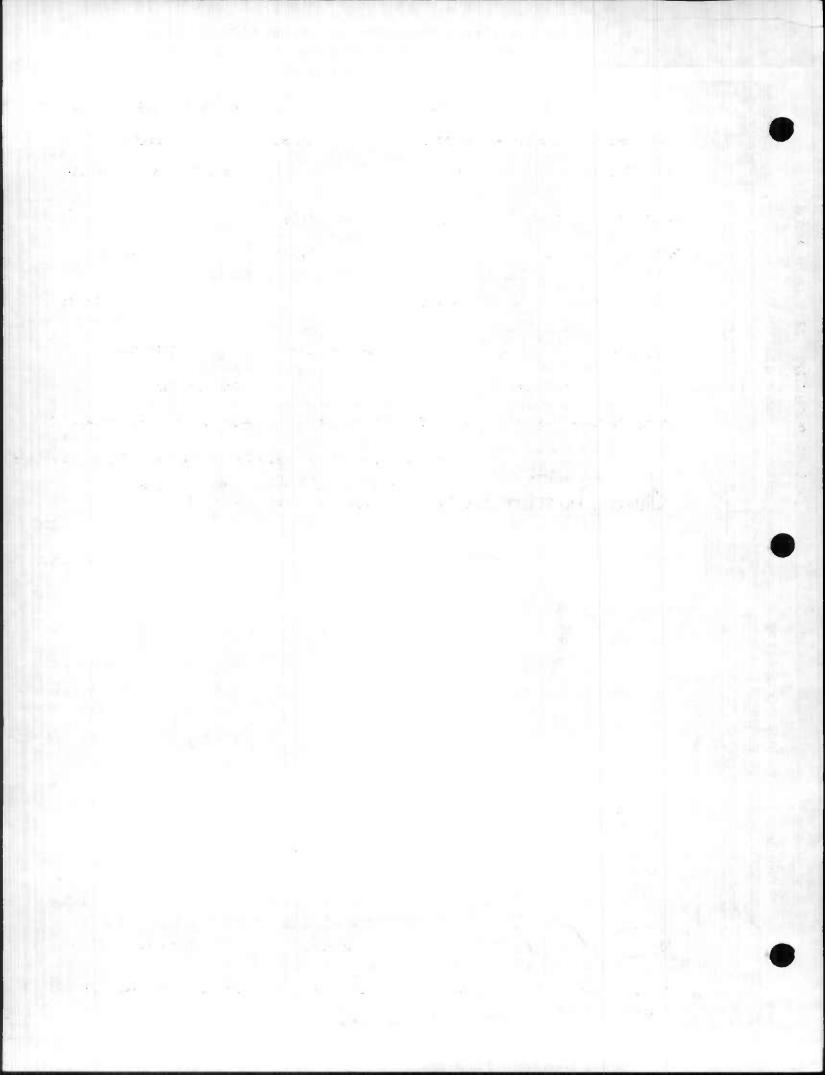
Certificate of Death

cian	Decedent'a Neme (First, Middle	Alton Ket	terman					2. Dete of De Month March	Dey	Yeer	Time of Death 9:00PM	
lical iner	4e Fecility Neme (If not institution					4	b. City, Town, or Lo	ocation of Deeth	4c. County	of Deeth		
ıl r	VA MARYLAND H 5. Social Security Number 212-20-1534		SYSTEM Age (In yrs. Iasi 74	t birthday) Yrs.	If Under 1 Y Months D	ear eys	PERRY PO If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, De	CECI		(State or Foreign	
	Usuel Residence of Decedent 10e. State 10b. County		10c City T	Town or Loc	ation					10d I	nside City Limits	
ector	Maryland (Cecil	Too. Ony, 1	OWN OF EGG	Peri	-	ille		10g. Citizen of V	1	XXYes 2 No	
D.	10e. Street and Number Perryvilla Apt.	15			10f. Zip Co		21903			.S.A.		
/ Funeral Director	11. Maritel Status 1 Never Married 2 Merri	12. Was Decede	s? ⊒No		res Decedent Yes, specify	of Hi Cube	ispenic Origin? (Sp on, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	6			
d by	3 ☐ Widowed XXDivorced	Yeer or Date	s: 1947-5	0.5			-41		16b. Kind of Bu	WII	ite	
Completed	15. Decedent (Specify only highes Elementery/Secondery (0-12) Unknown	College (1-4c	or 5+)	(Give k life. D		ork done during most of working use retired) intenance Golf Course					y	
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0		ra Ketterma	ın					Eva Mathias				
-	19a. Informent's Neme/Reletions			19b. Mailing	Address (S	treet	end Number or Rur			State, Zip Coo	(e)	
= /	Cathy Vickers	(Details C1			-		1th Care Sy	stem, Per	rry Point,	Marylan	d 21901	
Succe.	20e. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or cametery, cremetory or other plece) 3/12/99 20c. Location - City or cametery, cremetory or other plece) Garrison Forest Cemetery 3/12/99 Owings Mil											
	21. Signature of Funeral Service	Licensee	n Sc	Le		at	ss of Fecility terson & , Maryla			me		
ו	23a. Part1. Enter the disease, or shock, or heert failure. List	complications that cause only one ceuse on eecl	sed the deeth, in line.	Do not ente	r the mode of	f dyin	ng, such es cardiac	or respiretory e	rrest,	Inte	proximete ervel Between set end Deeth	
r	Immediate Ceuse (Final disease or condition resulting In death)	e. PNEUM	ONIA							3	Weeks	
9			Due to (or e	s e consequ	uenca of):							
Examiner	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Course (Disease or injury c.											
an/Medical	Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of):											
ian	u.											
hysic	Pert II. Other significant condition		d tobacco use contribute to the cause of death									
ted by Physicia												
by									en eutopsy ormed?	eveileb	autopsy findings le prior to ation of ceuse h?	
by								perfe		eveileb comple of deet	etion of cause	
e Completed by	25. Was case referred to medical						28. Plece of Deel	perfo	Yes 2 No	eveileb comple of deet	etion of cause h?	
Be Completed by	25. Was case referred to medical examiner? 1 □ Yes 2 △ No	Hospitel: ₁ᡯ Inp	atient 2□EF	R/Outpatient	3□ DOA	Oth	er.	perfo	Yes 2 No	eveileb comple of deet	etion of cause h?	
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edical Certification: To Be Completed by	examiner? 1 Yes 2 No 27. Manner of Deeth 1 Netural 5 Pendin investig 2 Accident 3 Suicide 6 Could reterm 29a. Certifier 1 Certifylin	Hospitel: 1 Inp. 28e. Dete of I (Month,	njury 26 Dey Year) Injury - At home etc. (Specify) st of my knowles of examinetion	Bb. Time of Injury e, ferm, stre	M 28c. M eet, fectory, of	Injury Work 1 []	ler: 4 ☐ Nursing Ho y at k? Yes 2 ☐ No	performance to the (Check only). The control of th	Yes 2 No one) idenca 6 □Oth how Injury occur (Street and Numb wn, Stete) cause(s) and ma	eveilet comple of deel 1 Ye er (Specify) red per or Rurel Ro	le prior to tition of cause h? is 2 No No No No No No No No No No	
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State Registrar

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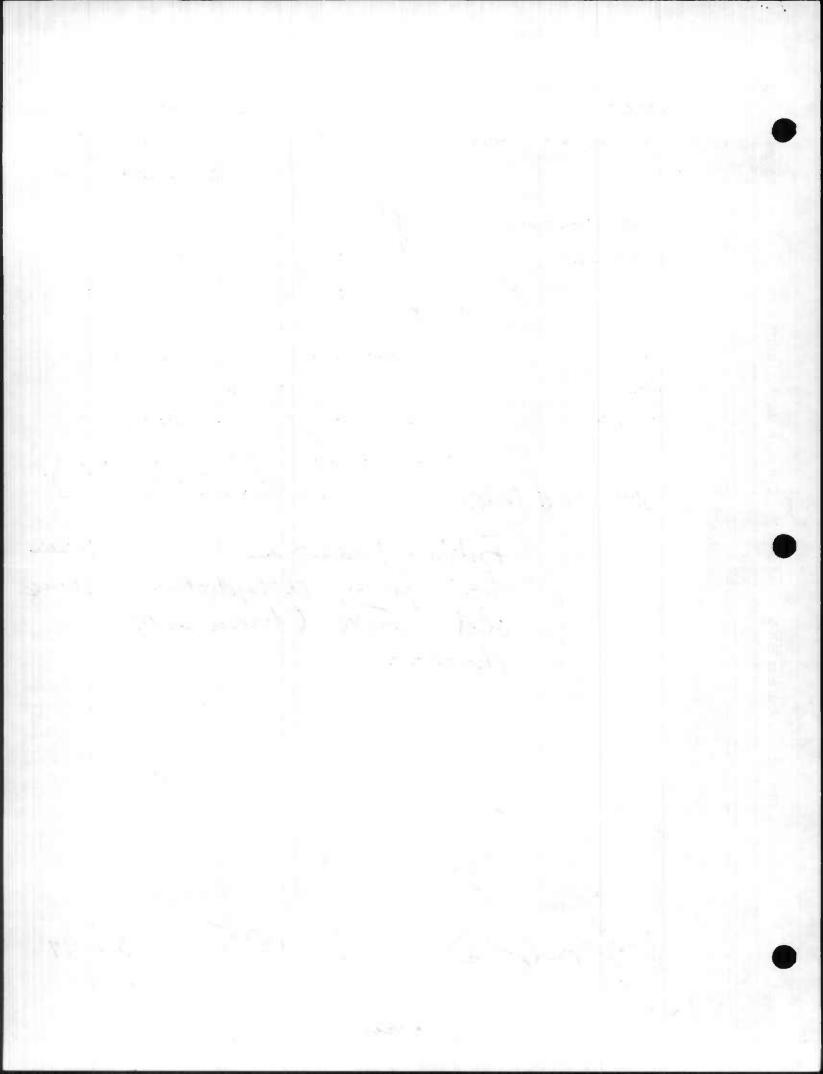
State of Maryland / Department of Health and Mental Hygiene

		Decedent's Neme (First, Mi	ddla la						Death	2. Dete of D	Reg. No.		10000	
Physician	ı										Day	Yeer	3. Time of Dec	
/Medical		GENYA		KHA						Februar			10:23	
Examiner	r	4e. Facility Neme (If not Institu	tion, give	e street end numi	ber)				4b. City, Town, or	r Location of Dee	th 4c. Cour	nty of Deeth		
		Suburban Hospi	-						Bethesd		Mon	tgomer	У	
uneral	- 1	5. Sociel Security Number	6. S	9x 7 □M 2X F	. Age (In yrs		Mont	hder 1 Year			irth lev. Year)	9. Birthp	elece (State or Fo	
rector		125-62-3865			81	Y	rs.							
	-	Usuel Residence of Decedent 10a. Stete 10b. Cou	ntv		100 0	ity Town	or Location			•				
THE PERSON	-	, , , , , , , , , , , , , , , , , , , ,	,											
be notified	2	Maryland Mont	gome	ery	Ro	ckvil							X Yes 2L	
Examiner name be notified at	5	10e. Street end Number					10f.	Zip Code			10g. Citizen o	f Whet Cour	ntry?	
1 6	0	6121 Montrose	Road	d				20	852		U.S.	Α.		
Funeral	2	11. Maritei Status		12. Wes Deced Armed Ford	ent Ever in I	J,S.	13. Was De	ecedent of I	Hispanic Origin? (Specify Yes or N	r No- 14. Race - American Indien,			
Ē		1 Never Married 2 N		1 Tes 2	Ĭ No			s 2X No		10 1 110411, 010.7			etc.	
b v		3√ Widowed 4 □ Divord	ed	Year or Det	es:		10.	2 220110	ореску.		Spec	nty of Deeth t gomery 9. Birthplece (State or Foreign Country) Ukraine 10d. Inside City Limits 1 Yes 2 No of Whet Country? A. ace - American Indien, ieck, White, etc. city: White Business/Industry e Manufacturer eme) m, Stete, Zip Code) 22102 n - City or Town, Stete ale, New York DC 20012 Approximete Intervei Between Onset end Deeth contribute to the cause of death? 3 Probably Unknown 24b. Ware autopsy findings availeplet pin of to condeath? 1 Yes 2 No ther (Specify)		
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event Be (17. Fethar's Name (First, Midd	le, Last)											
To	5	Nakum Khaet							UNKNOWN		10d. Inside City Limit 1			
	1	19e. Informent's Name/Rejetion	nship (7	ype, Print)		19b. F	Aaiiing Addr	ess (Street			ber City or Tow	n State Zin	Code)	
5		Helen Kharab,												
other traumatic event, the Medical	-	20a. Method of Disposition 20b. Place of Disposition (Neme of												
5		12 Buriel 2 ☐ Cremetio			ata	cemetery,	cremetory o	or other ple						
9	-	4 Donetion 5 Other	-		Mt	. Car	mel C			25,1999	Glen D	ale, N	lew York	
once		21. Signeture of Funeral Servi	oe Licens	900	1		22. Nama	and Addre	ess of Fecility	mo Inc				
a o	Takoma Funeral Home, Inc. 254 Carroll St. NW Washington, DC 20012 23e. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, International Complex													
		23e. Part . Entar the diseese,	or comp	licetions thet cau	sed the dee	th. Do no	t entar the n	node of dyin	ng, such es cardie	oc or respiretory	errest,	00 200	Approximete	
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by													XX	
										24e. Was	an autopsy	24b. Wa	re autopsy findin	
Completed	-									pert	ormed?	cor	mplation of cause	
Ē												OI C	aetn?	
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ati		2 Accident inves	tigetion			1	М		Yes 2 No					
Certification:		3 ☐ Suicide 6 ☐ Coui	d not be mined	28e. Piece of	Injury - At h	ome, ferm	, street, fact	tory, office		28f. Location	Street and Num	ber or Rure	Route Number,	
9		4 El Homodo		building,	etc. (Special	(V)				City or 10	wn, Stete)			
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	L	Kathorine R Lillie M. D-532						244		March 4	, 199	9		
	3	0. Nema end address of parso	n who co	ompiated causa o										
		Katherine R. I	illi	ie, MD	1114	40 Ro	ckvil	le Pi	ke # 348	Rockvil	lle, MD	20852		
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egistrar		MAK 0 4 19	99	125		- 4	-							

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			Oldio of III	ar y rai re	Cer	tificate	e of	Death			Reg. No.	0	8804
		1. Decadant's Nama (First, Middla, Las	st)							2. Data of De Month		Yaar	3. Time of Death
Physicia /Medic		ROOSEVELT		KENO	N						2, 1999		2:15 a.m.
* Examin	_	4a Facility Nama (If not institution, give	street and number)					4b. City, Tov	vn, or Lo	cation of Deat	4c. County		
		Southern Maryland	Hospita	1					nton		Prince		
Funeral		5. Social Sacurity Number 6. S	ex 7. Ag □ M 2 □ F		ast birthday) Yrs.	If Under Months	1 Yaar Days	if Under 2 Hours	Min.	8. Data of Bir (Month, Da			aca (Steta or Foreign ry)
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Mary	o	Manufand Duines C			014-								Yas 2□No
the notified	Director	Maryland Prince G	eorge's	1	Clir	10f. Zip	Coda				10g. Citizan of V	/hat Count	ry?
3a or		9211 Stuart Lane				207	725				USA		
death	Funeral	11. Marital Status	12. Was Dacedant	Ever in U,S	S. 13. \			lispanic Orig	in? (Spe	cify Yes or No Rican, etc.)		- Amarica	
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Maryland 2 d 2 should be filed th and Mentel Hygi 7 le marked other traumatic event, I	2	UNKNOWN 19a. Informant's Name/Ralationship (7)	Time Print)		10b Moilin	o Addraer	/Strant	MAM:		KENON	er, City or Town,	State Zin	Code
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other tr	1	20e. Mathod of Disposition		20b. Pl	aca of Dispo	sition (Nam	a of			Date	20c. Location -		
		1 Burial 2 □ Cramation 3 □ 4 □ Donation 5 □ Other (Specify			matary, cran est Hi					3-8-99	Clinton	Mon	vland
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B F F F F F F F F F F F F F F F F F F F		k DIAWAW &	1 Know	bon							nd, Mary		
	-	23a, Part 1, Enter tha disaase, or comi	olicetions that cause	d the death									Approximata
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tha d	ıysı	Part II. Other significant conditions of	ontributing to death b	ut not rasu	Iting in tha u	ndariying ca	ause gh	van in Part I.		./			the causa of death?
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Division or Attending after death. Director: After	Hica	3 ☐ Suicida 6 ☐ Could not be	Zoa. Flaca of In	jury - At hor	ma, farm, str	eet, factory	, offica		1	28f. Location (Streat and Numb	er or Rura	Routa Number,
Die after	Certification:	4 Homicida	building, at	c. (Specify	,					Chy or 10	wii, Giaia)		
Division To the Hospital or Attence with 24 hours after death of the Funeral Director: completely filled in by the		29a. Cartifiar 1 Certifying Ph	ysician: To the best	of my know	vledga, daath	occurred a	at the ti	me, data end	d plece, a	and dua to the	causa(s) and ma	nnar as st	ated.
he Hu 124 Te Fu	edical	one) 2 Medical Exam	inar: On the basis o and manner st		on and/or in	astigation,	in my c	opinion, deat	n occurre	ed at tha tima,	data and piaca,	and dua to	ma cause(s)
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		30. Nema and addrass of parson who	completed causa of	teath (ttam	23a) (Type,	Print)							
		LAXMI BERWA, MD				ve. C	101	Clint	ton,	Maryla	nd 207	3.5	
Sta		31. Data tilad (Month, Day, Year)	32. Registi	rar's Signet	ure								
Registra		MAR 0 2 1999	227	159	Low	the							
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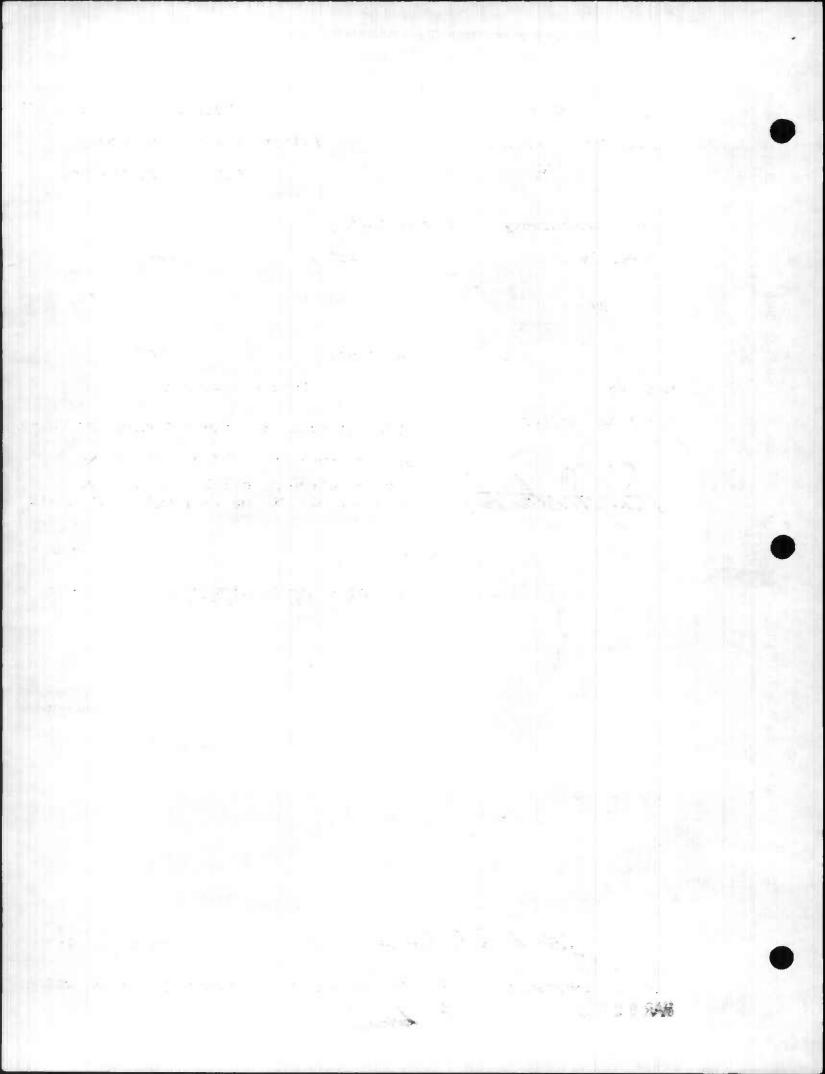
State of Maryland / Department of Health and Mental Hygiene

				Centi	ificate o	f Death		Reg. No.	0 0	0000				
nysician	Decedent's Name (First, Middle,						2. Data of De Month February	Dey	Year 999	3. Time of Deeth				
Medical xaminer	Marvin W. K.)			4b. City, Town, or				1930				
Xanınıcı	Howard County G	eneral Host	oital			Columbi	ia	Howa	rd					
neral	5. Sociel Security Number 8		ge (In yrs. le	ot billingy/	If Undar 1 Ye Months Day	ar If Under 24 Hrs.		th y, Year)	9. Birthpla	ca (Stete or Foraign				
ector	217-42-1140 Usuel Residence of Decedent	W 20 P	54	Yrs.			May 13,	1944	Washi	ngton, D.C				
н	10e. State 10b. County		10c. City	Town or Loca	ition				100	d. Inside City Limits				
Examples must be notified at by Funeral Director	Maryland H	oward	E1	licott	City		1 □ Yas 2 ☑ No							
be notified Director	10e. Street and Number				10f. Zip Cod			10g. Citizen of	What Country	y?				
ralle	3134 Normandy W					21043		United						
funer munt	. 11. Maritel Status 1 □ Never Married 2 □ Marrie	12. Was Decedent Armed Forces? 1 Yes 2	?	5. 13. We	as Decedent of as, specify C	of Hispenic Origin? (Suben, Mexican, Puerl	to Rican, etc.)	Ble	ce - American ck, White, et					
by F	3 ☐ Widowed 4 ☑ Divorcad	If Yes, Give Yaar or Dates:	140	10	☐Yes 2型N	lo Specify:		Specif	y: Wi	nite				
eted by	15. Decedent's			16a. Deceder	nt's Usuel Oc	cupation ne during most of wo	rkina	16b. Kind of B	usiness/Indu	stry				
completed	(Spacify only highast Elementary/Secondary (0-12)	College (1-4or	5+)	_		ired)	inniy.							
	10	- 41		Plumbe	er	40 Markada Nav	(First & Sidelle		umbing	3				
Be Be	17. Fathar's Name (First, Middle, La					18. Mother's Nac	ma (First, Middle, en Nimn		110)					
To	Marvin W. Kidwe			19h Mailing	Address (Str	eet and Number or Ri			State Zin C	Code)				
trac	Steven Eugene H					woods Dri								
othe	20e. Method of Disposition	CEGWCEE DON	20b. Pl	ace of Disposit	ion (Neme of		Dete	20c. Location						
70	1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			t Linco			3-5-99	Brentwo	ood, Ma	aryland				
y injur	21. Signature of Fugeral Servica kg	censee	101	22.1	Name and Ad	dress of Facility								
£ 8	Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, Maryland 2													
cian	23a. Part . Enfor the disease, or conshock, or heart feilura. List or Immediate Causa (Final					with Trac			1	nterval Between				
niner	disease or condition resulting in death)	a		as e conseque		With IIde	ileo d'I o ile							
ner ner				astasis										
Examiner	Sequentially list conditions,	b		es e conseque										
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury	C	Sever	e Chron	ic Obs	tructive	Pulmonar	y Disea	se					
as the bunal-transit edicai Examir	thet Initiated events resulting in death) Last		Dua to (or	as e consequa	ince of):				1					
a		d												
detached for use / Physician/M	Part II. Other significant condition:	contributing to death b	out not resu	Iting In the und	lerlying cause	given in Part I.	23b. Dld	tobacco uae co	ontribute to t	he csuse of death!				
Phys							1図	Yes 2 No	3 Probe	ibly 4 Unknow				
2									T 111					
Completed								an eutopsy ormed?	avail	e autopsy findings leble prior to pletion of causa				
mpleted										eath?				
Com							10	Yes 2 No	10	Yes 2□ No				
Be Be	25. Was case referred to medical exeminer?	Hospitel:			34	Other	ath (Check only							
To To	1 ☐ Yes 2 🛣 No 27. Manner of Death	1 Inpati		28b. Time of	3E DON	4 🗆 Nursing r	Home 5 Resi	danca 6 ∐Ot how injury occu						
the tuneral	1 Natural 5 Pending 2 Accident Investiga	(Month, De	y Year)	Injury		njury et Work? I □ Yas 2 □ No								
Certification:	3 Suicide 6 Could no determin	ed 286. Place of in	jury - At hor tc. (Specify		et, factory, offi	Ce	28f. Location (City or To	Street and Num wn, State)	ber of Rural	Route Number,				
completely filled in by Medical Certifi	29a. Certifier 1 Certifying 2 Medical Ex	Physician: To the best cominer: On the basis of end manner st	of examinati	riedge, death o on and/or inve	occurred et the stigetion, in m	e time, date and place by opinion, death occur	e, end due to the urred at the time,	ceuse(s) end m date end place	enner as sta , and due to t	ted. he cause(s)				
Mec	29c. License number 29d. Date signed (Month, Dey, Year)													
-	D13687 March 2, 1999									99				
0						111 1111111		ALCO A WILL	- 9 - 1					
(0)	30. Name and address of person w	no completed cause of	death (Item	23a) (Type, Pi	rint)									

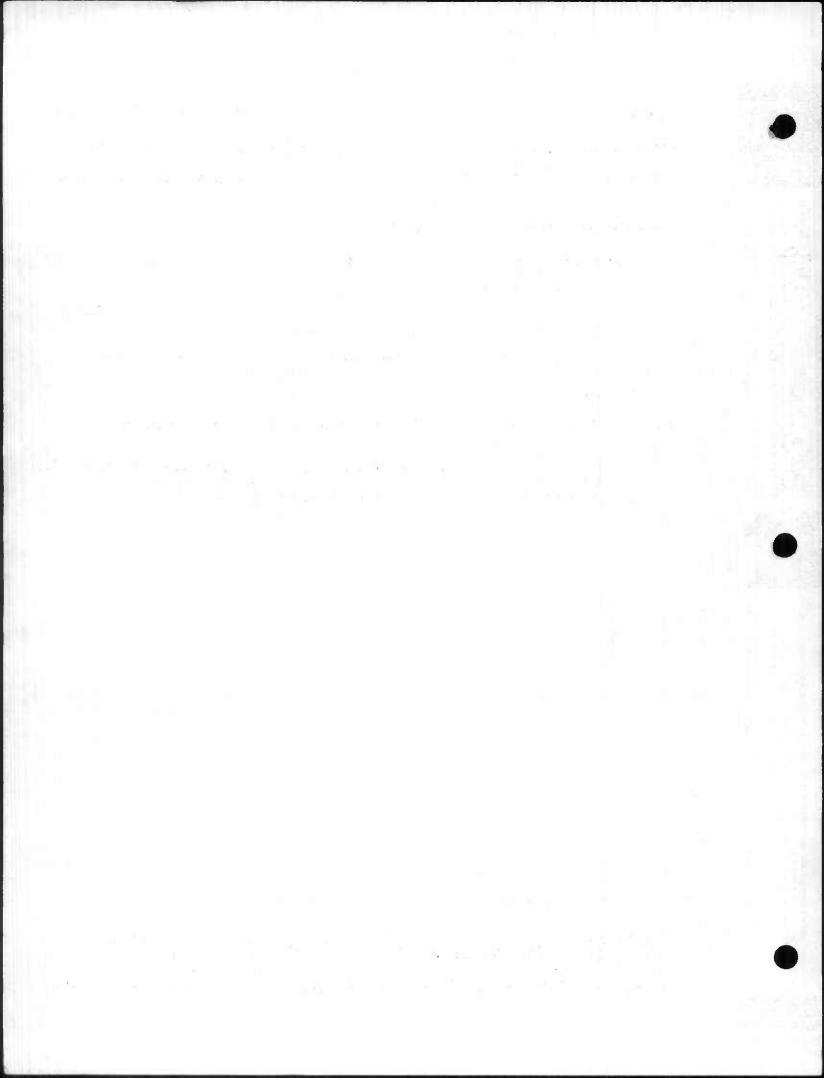
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State of Maryland / Department of Health and Mental Hygiene

			Cer	tificate of	Death		Reg. No.	08806					
Physician	1. Decedent's Name (First, Middle, Las	()		2. Date of Death Month Day Yeer 3. Time of I									
/Medical	Fred Kugle					Feb.		1999 8:50 PM					
Examiner	4a Facility Name (If not institution, give				4b. City, Town, or I								
	Holy Cross H		4 44 4 4 1	If Under 1 Year	Silver		-						
Funeral Director	5. Social Security Number 578-48-6406 Usual Residence of Decedent	XM 2□ F 7. Age (in yr	s. lest birthday) Yrs.	Months Days		(Month, De	y, Year) 8 1921	Country) New York					
yeu w	10a. State 10b. County	10c. 0	City, Town or Lo	cation				10d. Inside City Limits					
with the Merylence or 28s-1 show	MD Montgo	mery S	ilver :	Spring				1 ☐ Yes XIXN					
vith the Mer or 28a-f sl	10e. Street and Number	mery .	11/01	10f. Zip Code			10g. Citizen of V	Vhat Country?					
23a c	509 Dennis Ave			2090	2		USA						
urs efter de Mr, or fterre Exerciser re by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Nivorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates:		Vas Decadent of Yes, specify Cub	Hispanic Origin? (S pan, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		ek, White, etc.					
9 1 9	15. Decedent's Ed (Specify only highest gra-	de completed)	(Give	lent's Usual Occu kind of work done OO NOT use retire	during most of wor	king	16b. Kind of Bu	isiness/industry					
jene. r than "r r omple	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		torney			Law						
= 1 4 2 a	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle	, Maiden Sumern	en of What Country? A. Raca - American Indian, Black, White, etc. Specify: White Ind of Business/Industry Industry					
Mental Merked of Metic ev	Sam Kugler				Sophie	Levin	son	10d. Inside City Limi 1 Yes XX In of What Country? A Race - American Indian, Black, White, etc. pecify: White I of Business/Industry aW Immeme) Town, State, Zip Code) ring, MD 2090 Ition - City or Town, State 1 phi, MD ral Home ton, DC 20012 Approximate Interval Between Onset and Death 3 Days 4 Years 4 Years I years 4 Years 24b. Were autopsy finding available prior to collected y 24b. Were autopsy finding available prior to collected y 24b. Were autopsy finding available prior to collected y 24b. Were autopsy finding available prior to collected y 24b. Were autopsy finding available prior to collected y 24b. Were autopsy finding available prior to collected y 24b. Were autopsy finding available prior to collected y 24b. Were autopsy finding available prior to collected y 24b. Were autopsy finding available prior to collected y					
end end m	19a. Informant's Name/Relationship (7		19b. Mailin	g Address (Stree	t end Number or Ru	ıral Route Numb	er, City or Town,	State, Zip Code)					
F Health tem 27 other tr	Daniel Kugler/S 20a. Wethod of Disposition												
Peges net of int: If its iry or o	f Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	nemoval from State		sition (Neme of netory or other ple		3/1/99	Adelp						
permit. Pege Department of Important: If I any injury or pace.	21. Signature of Fundral Service Licen-												
	23a Part Enter the disease, or companies, or bart failure. List only	lications that caused the de						Approximate interval Between					
Physician (1)		Pneum											
/Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth)		3 Days										
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executed in end iel-trensit Examiner	Securation the list conditions	4 Years											
an en riel-tr													
filicate be executed g physician end es the buriel-trensit Actical Examin	that initiated events	c. Due to	(or as a consequ	uence of):									
5 6 5	resulting in death) Last												
at the death cer by the attendin eteched for use		d											
by the a reched for the checke	Pert II. Other significant conditions of	ntributing to death but not re	esulting In the ur	nderlying cause g	iven in Part I.	23b. Dld	tobacco use co	ntribute to the cause of death					
es that the igned by be detected by Phy						10	Yes 2□ No	3 Probably Munknow					
een s hould							an autopsy ormed?	completion of cause					
hes b ge 2 s							VV						
icete he								1 Yes 2 No					
Physician: The this certificate ral director, page to Be Co	25. Was case referred to medical examiner?	Hospital:		01	hor	ath (Check only							
Physic raldic raldic	27. Manner of Death	28a. Date of Injury	☐ ER/Outpetien 28b. Time of	1 SLI DON	4 🗆 Idaising i	,							
ding l h. After fune fune	1 Naturel 5 Pending 2 Accident investigation	(Month, Dey Year)	Injury	M 1	ork?]Yes 2∐No								
lal or Attending P is after death. al Director: After t ed in by the funers Certification:	3 Suicide 6 Could not be determined	28e. Placa of Injury - At building, etc. (Spe	home, farm, stre cify)	eet, factory, office		28f. Location (City or To		9. Birthplace (State or Foreign Country) 1921 New York 10d. Inside City Limits 1 Yes XIXNo 11d. Raca - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Law Maiden Sumeme) 300 City or Town, State, Zip Code) Spring, MD 20902 20c. Location - City or Town, State Adelphi, MD Tuneral Home aington, DC 20012 Approximate Interval Between Onset and Death 3 Days 4 Years A Years 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No					
Hospi 4 hou Funer tely fill	29a. Certifier 1 Certifying Phy (Check only one)	raician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, death nation and/or Inv	occurred at the trestigation, in my	ime, date and place opinion, death occu	a, and due to the urred at the time,	cause(s) and me date and placa,	enner es stated. and due to the cause(s)					
within 2 To the comple	29b. Signature and title of cartifier	mon	0	29c. Licen	se number		29d. Date signe	d (Month, Dey, Year)					
- 5 - 0	> Sille	o stration	amedia		37975	E	ebruar	y 28, 1999					
	30. Name and address of person who d					- 1 -							
	Jeffrey Ingri			est Gl	en Rd.,	Silve	Sprin	g, MD 20910					
State	Jay Ded Monin Day Year)	32. Registrar's Sig	riature										



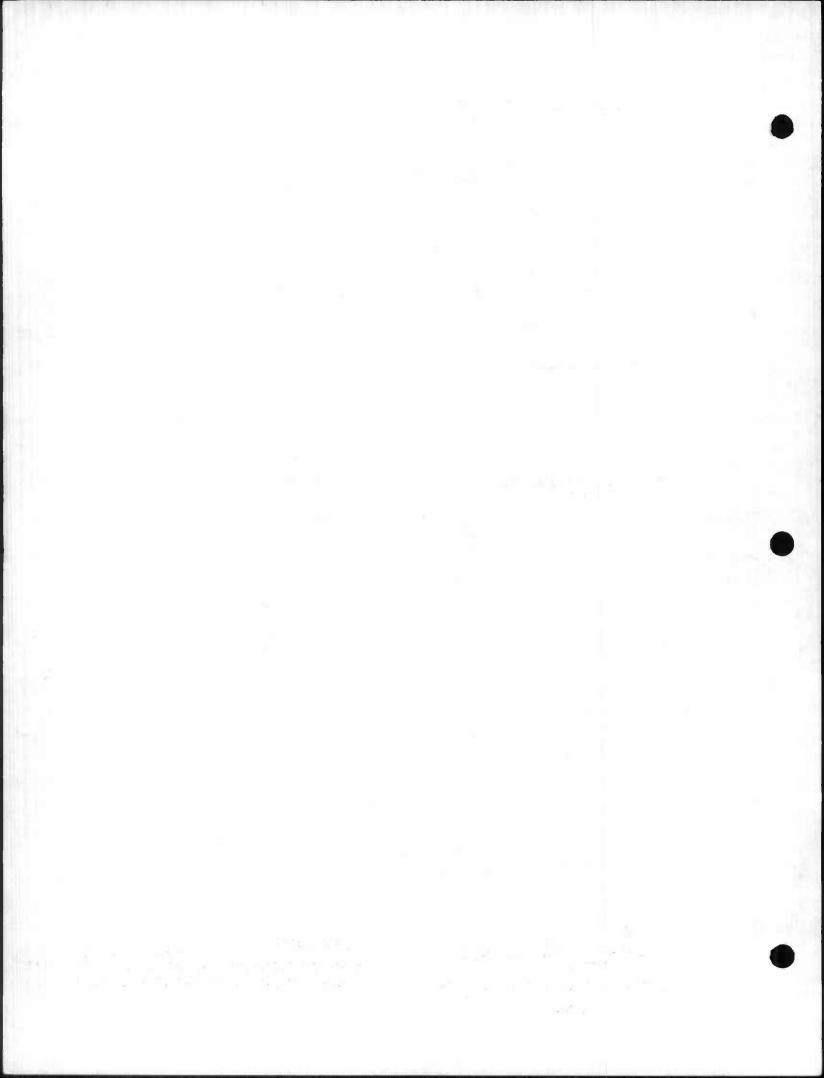
				State 0	n iviai yid		certificate of		nemai ny	Reg. N	and and	ПQ	007
- 1	Physic		1. Decedant's Nama (First, Middle, Catharine Horst				-		2. Date of D Month March		ay 1999	Year	3. Time of Deeth 8:17 p.m.
	/Medi Exami		4a. Facility Nema (If not institution,		m <i>ber</i>)			4b. City, Town, or L		-	c. County of		0.17 p.m.
2			Homewood Nursin	12 Home				William	sport		Washi	ngto	on
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☒ F		rs. last birtho	Months Days	If Undar 24 Hrs.	8. Date of B	irth ay, Year	r)	9. Birthp	piaca (State or Foreign
- L	Director		212-58-7552 Usuel Rasidence of Dacedant		85				Aug.	5 1	913	Mar	yland
	stylan show dat	-	10a. Stata 10b. County		10c.	City, Town o	r Location					1	0d. Inside City Limits 1 ☐ Yas 2 ☐ No
	r 28a-f show notified at	Director	Maryland Wash:	ngton		Hage	rstown			10- 0	itizen of W	200	15.00
19	with w						10f. Zip Coda	0				net Coun	nry r
10	mag	era	19105 Longmeado	NW Koad	edent Evar in	115	2174		ecify Yes or N		S.A.	- Americ	ean Indian,
000	or the miner	Funeral	1 ☐ Navar Merried 2 ☐ Marrie	Armed Fo	orcas?		 Was Dacedant of I If Yas, specify Cub Yes 2 No 		Rican, atc.)		Biack	c, Whita,	
and 21215-0020	ural'.	d by	3 ☐ Widowed 4 ☐ Divorced	Yeer or D	ates:						Specify:	V	White
5	in 72 h	Completed	15. Decedant's (Specify only highast	grade completed)		16a. Do	ecedant's Usual Occu iiva <i>kind of work don</i> a 'a. <i>DO NOT</i> usa <i>retire</i>	pation a during most of work ed)	king	16b. I	Kind of Bus	inass/inc	Justry
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2	tal Hyg d other event,	Be	17. Father's Name (First, Middla, L	nst)				18. Mothar's Nam	a (First, Middle	e, Maide	n Sumama	1)	
aryla	Media	To	Samuel Petre					Clara S					
Mag	d 2 sho th and 7 is me traum		19a. Informant's Name/Rejetionsh Donald L. Kline				lailing Addrass (Stree						
me.	Has Has		20a. Mathod of Disposition	e - Son	200	b. Place of D	01 N. Arli		Data		Location - (
altimor	Pages sent of mit: Iff its ary or o		1 Buriel 2 □ Cremation 4 □ Donation 5 □ Othar (Spi				cramatory or othar pla aven Cemet		3/6/99				Maryland
W#	いると		21. Signature of Funeral Service L	censee		ivest ii	22. Name and Addre		linnich				
	Dec Dec amy amy and a		1200	MIN	less	u	₩15 E. Wi	llson Blvd	l. Hag	erst	own,	Mary	land
			23a. Part1. Enter tha disaasa, or o shock, or haert failura. List o	omplications that c	aused the data	aeth. Do nat	tha mode of dyl	lng, such es cardiec	or respiretory	arrest.			Approximata Intarvai Between
	Physician / /Medicai		Immediata Cause (Finei	4	(1.7)=	- De	-110- 7	Four	سے			(Onset end Death
	Examiner		disease or condition rasulting in death)	a	Due to	o (or es a cor	nsequence of):	FAILUR				6	WELTER
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	ficate be executed physician and is the bunal-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	1		o (or as a cor	sequance of):	())				(- 1 p.
68760,	sician buris	edical E	thet initiated evants	c. EN	11	60 1	+ CZ+FETW sequence of):	ren !!) (SCAS	. 6		10	100 9 GAL
	E 00 %		resulting In death) Last		546 (0	(or as a con	sequative oi).					ŀ	
€ X	hat the death certif ed by the attending detached for use a	Physician/M		d								1	
Co	0 0 0	ysic	Part II. Other significant condition	s contributing to de	eath but not r	rasulting in th	e underlying cause gi	iven in Pert I.	23b. Dic	tobacc	o use con	tributa to	the cause of death?
- d.	The law requires that the ste has been signed by the page 2 should be detache		Premay	A					1] Yee	2 No.	.3 Prot	bebly 4 Unknown
rds	aulres n sign	ed by	1						24a. Wa	s an aut	opsy		ara autopsy findings
000	aw requir is been s 2 should	Completed		·					pen	formed?		COL	allabla prior to mpletion of cause death?
9.4		E O							1 🗆	Yas 2	2 No	10	Yes 2□ No
/ita	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?					26. Placa of Deal	th (Check only	ona)			
10	this aldi	2	1 Yes 2 No			□ ER/Outpe	tient 3LI DUA	har: 4 Norsing He					y)(y
- 6	ding h. After funer	tion	1 ☐Naturai 5 ☐ Pending		of injury th, Day Year)	28b. Tim Inju	ry Wo	iryat ork?]Yas 2∐No	28d. Dascribe	now inj	ury occurre	ю	
TOIS	l or Attending after death. Director: After f in by the fune	flca	3 Suicide 6 Could no	t be 28e. Plece	of fnjury - Al	t homa, farm	, street, factory, office					or or Rura	al Routa Number,
() =	244	Certification:	4 ☐ Homicida	buildi	ng, etc. (Spe	ecify)			City or To	wn, Sta	ta)		
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai	(Check only 2 Medical E	caminer: On the ba	asis of axami	knowledge, d Ination and/o	aeth occurred at tha ti r invastigation, in my	ima, data and piace, opinion, death occur	and dua to the red at tha time	causa(s) and men	ner as st	teted. the cause(s)
	ithin 2 o the	Med	one) 29b. Signature and this pl/cortifer	end meni	nar stated.		29c. Ligen:						Day, Year)
	F 3 F 0		H. 4011	Du=51	car 1	1017	an T	1706	7	3	14/6	30	
			30. Name and address of purson w	complated caus	se of deeth (II	tam 23a) (Ty	pe, Print) /	/	/	1	11	1-1-	, /
			STEPHEN E.	LETZUE	nil	u)	747 Non	THEN A	us t	ACA	51579	een	mol
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State of Maryland / Department of Health and Mental Hygiene O

					Ce	ertificate	of Death		Reg. No.) [8808
Physici	an.	1. Decedant'a Name (First, Middle,			44 h. 1			2. Data of De Month	ath Day	Year	3. Tima of Death
/Medic		DIANE .	ANDREWS 1	LAW				Februa	ry 28,		2240
Examin	er	4a. Facility Nama (If not institution,	A CONTRACTOR OF THE PARTY OF TH					, or Location of Deat	4c. County	of Death	
		U.S. Navy Recrea				1 4	Solon			vert	
Funeral Director		5. Social Security Number 435-68-7793 Usual Rasidanca of Decedent	. Sex 7. A 1 □ M 2	ge (In yrs. 1	last birthdaj Yrs.	Months		Min. (Month, Da	th ly, Year) r 3,1946	9. Birthp Coun Ala	lace (State or Forai itry) bama
Aeryland ahow	or.	10a. State 10b. County			y, Town or I					1	0d. Insida City Limit
he A	Director	Maryland Calver 10e. Street and Number	t	Lo	thian						21
No Mith	급					10f. Zip (10g. Citizan of V		•
ath 23	ral	5381 Sands Road	10.00			207			United		
permit. Pages 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f ahow any injury or other traumstic avant, ira Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Navar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedan Armed Forcas 1	? [No	If Yas, specify Cub			n? (Specify Yes or No Puarto Rican, atc.)	Specify:		
72 ho	te d	15. Decedant's (Specify only highest	Education		16a. Dec	edant'a Usual	Occupation	d considera	16b. Kind of Bu	usinass/înc	duatry
min min	Completed	Elamantary/Secondary (0-12)	College (1-4or	5+)	lifa.	DO NOT use	dona during most of retired)	-	II C D1	1	77 7 4-1-
d wi	NO.		4	.,	Cont	racting	g Officer		U.S. Pul	SILC	ervice
office of the vant	Be	17. Fathar'a Name (First, Middla, La	st)				18. Mothar's	Nama (First, Middla	Maidan Sumam	10)	
Aents Aents Treed tic a	70	James Andrews					Evelyr	n Brantley			
ohe ohe		19a. Informant's Name/Ralationship	(Type, Print)		19b. Ma	lling Addrass (Street and Number of	or Rural Routa Numb	er, City or Town,	Stata, Zip	Coda)
od 2 lith a 27 le r tra		Marvin Law,	Husband		5381	Sands	Road. Lot	thian, Mar	vland 20	0711	
He de de de de de de de de de de de de de		20a. Mathod of Disposition		20b. P		position (Name ematory or oth		Data	20c. Location -		wn, State
age ont of		1 Burlai 2 Cremation 3		1				0 /0 /00			
rtan njun		4 Donation 5 Other (Spe		Met			rematory	3/3/99	Alexandi	cia,	Virginia
Depar Impor any ir			lankenship		0857	Brinsi 22955	Hollywood	eral Home, d Road, Le	onardtov	wn, M	D 20650
DRUF		23a. Part1. Entar the disease, or co shock, or haart failura. List or	emplication that cause ily one cause on each	d tha daath lina.	n. Do not e	ntar tha mode	of dying, such as ca	rdiac or raspiratory a	rrest,		Approximata Intarval Between Onset and Death
hysician /Medical		Immediate Causa (Final								1	Oriset and Death
/Medical Examiner		diseasa or condition resulting in daath)	INTE	AORAL	GUNS	OW TOH	UND			1	
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cate be executed physician end a the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated evants	0.	Dua to (or as a consaquance of):							
E 000	Physician/Medical	that initiated events resulting in death) Last	С	Dua to (or	aa a conse	equence of):					
attendin for use	an		d								
dea deat	100	Part II. Other significant conditions	contributing to death	but not rasu	Ilting in tha	undarlying car	usa givan in Part I.	23b. Dld	tobacco usa cor	ntribute to	the cause of deal
es thet the de igned by the a be detached	by Phy							10	Yes 2⊠ No	3 Prot	pebly 4 ☐ Unkno
aw requir	Completed							24a. Was	an autopsy rmed?	ava	are autopsy finding allable prior to mpletion of cause daath?
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certificate rector, pa	Be	25. Was casa rafarred to medical					26. Placa of	Death (Check only	ona)		
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rthi	-	27. Mannar of Death	28a. Data of Inj	ury	28b. Tima		c. injury at Work?	-	how injury occur		//
r death. octor: After th by the funeral	후	1 □ Natural 5 □ Panding 2 □ Accident investigal	ion February		2205	м	Work? 1 ☐ Yaa 2 ☑ No	Apparen	t self :	infli	cted
after death. Director: A in by the fe	Certification:	3 Sulcida 6 ☐ Could no	be an Bloom					Apparent self inflicte gunshot wound 28f. Location (Street and Number or Pural Pour			I Route Number
in the	팊	4 ☐ Homicida datarmine	building, a	tc. (Specify)						
ied peili			U.S. Na								,Solomon
Fune Tely f	edical	(Check only 2 Medical Ex	Physician: To the best amtner: On the basis of	of my knov of axaminat	vledga, daa ion and/or i	th occurred at nvaatigation, is	tha tima, data and p	place, and due to the occurred at the time.	causa(s) and ma data and place, a	nnar aa at and dua to	ated. tha causa(s)
within 24 hours after death. To the Funeral Director: A completely filled in by the fi	8	one)	and mannar s	tated.				ar ar arm mild,			
To	Σ	29b. Signature and title of certifier	0				Licensa number		29d. Data signed	1 (Month, I	Day, Year)
		1 /	1	O.		3	9542 (MN)		Mar 2	19	99
7 1	30. Name and address of pennsy who completed cause of death (Itam 23a) (Type, Print) OFFICE OF THE MEDICAL EXAMINER (
		ANDREW M. BAKE				,		ITUTE OF 1			
Country	CC III					10	MODO THOI	TIOTH OF I	111101100	- , 110	
Star Registra	e sr	31. Data filed (Month, Day, Year) MAR 05 199	39 September 19	rar's Signat	G.	Loon	6				



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State of Maryland / Department of Health and Mental Hygiene 9 9 8 9

	Decedent's Neme (First, Middle, Last)	Certificate of L	2. Dete of De					
Physician · /Medical	Everett F. Lomax		Month Mar. 2	2, 1999 Year 5:54 AM				
Examiner	4a Fecility Name (If not institution, give street end number) HOLY Cross Hospital		b. City, Town, or Location of Deeth	4c. County of Deeth				
Funeral Director	5. Sociel Security Number 6. Sex 577-28-8035 Usuel Residence of Decedent		Silver Spring	y, Year) 9. Birthplece (State or Foreign Country)				
/land	10e. Stele 10b. County 10c. City, Town	n or Location		10d. Inside City Limits				
the Merylar 28a-f show notified at	MD Montgomery Silve	er Spring		1 □ Yes 2√7 No				
or 28	10e. Street end Number	10f. Zip Code		10g. Citizen of Whet Country?				
th wi	14510 Home Crest Rd.	2090		USA				
If yield A LA 12-00.00 should be filed within 72 hours efter death with the Menyland and Menlel Hygiene. marked other than "natural", or items 23s or 28s-1 show marke event, the Besitest Example motilled at To Be Completed by Funeral Director	11. Maritel Status 11. Maritel Status 12. Wes Decedent Ever in U.S. Armed Forces? 1 Syes 2 No 1942. 14. Widowed 4 Divorced 15. Wes Decedent Ever in U.S. Armed Forces? 1 Syes 2 No 1942. 14. Wes Decedent Ever in U.S. Armed Forces? 1 Syes 2 No 1946.	13. Wes Decedent of Hi If Yes, specify Cube 1 ☐ Yes XX No	spenic Origin? (Specify Yes or No- n, Mexicen, Puerto Rican, etc.) Specify:	14. Race - American Indian, Black, White, etc. Specify: White				
TOTE, MATYIANG ALAIS-UOZU ges 1 and 2 should be filed within 72 hours of it of Health and Mentel Hygiane. If flem 27 is marked other than "natural", or or other traumatic event, the Medical Exam To Be Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+)	Decedent's Usuel Occupe (Give kind of work done of life. DO NOT use retired		16b. Kind of Business/Industry				
Cor of the	12 Exc	ecutive Se		Churches				
Maryland 214 d 2 should be filed with th end Mentel Hygiene. 7 Is marked other than traumatic event, the To Be Comi	17. Fether's Neme (First, Middle, Last) Wade H. Lomax		18. Mother's Name (First, Middle, Monimia Louis					
Taryica 2 should end Men is marke aurmatic			and Number or Rurel Route Number					
Health e			4 /	E				
Saltimore, semit. Pages 1 er Separtment of Hea mportant: If them: inty lnjury or other ince.	1 11 Buriel 2 Li Cremenon 3 Li Hemovel from State	Disposition (Name of ry, cremetory or other place		20c. Location - City or Town, Stete				
DESILTMORE, N permit. Pages 1 end Department of Health Important: if Item 27 any injury or other to	21. Signeture of Funerel Service Licensee	22. Neme end Addres	Cemetery 3/11/99 Cheltenham, MD Address of Fecility Takoma Funeral Home rroll St., Washington, DC 20012					
	23a. Part1. Enter the disease, or complications that ceused the deeth. Do shock, others feilure. List only one ceuse on eech line.							
requires that the death certificate be executed requires that the death certificate be executed representation and required by the ettending physician and bould be detached for use as the buriel-transit carried by Physician/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury	consequenca of):						
eath cert ettendin I for use			- 1 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					
hat the death cert ed by the ettendin detached for use	Pert II. Other significant conditions contributing to death buf not resulting in	n the underlying cause give		tobacco use contributs to the cause of death? Yss 2□ No 3□ Probably 4ሺ Unknow				
			24e. Wes perfo	en eutopsy rmed? 24b. Were autopsy findings eveileble prior to completion of cause of deeth?				
VITAL MEC sician: The law certificate hes b lirector, pege 2 s			10	Yes 2 KNo 1 □ Yes 2 □ No				
Physician: This certific ral director,	25. Wes case referred to medical	la.	26. Plece of Deeth (Check only of	one)				
= > · · · · ·	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou		4 Littership frome 5 Linesh					
ath. ** After the funer ation:	1 Maturel 5 ☐ Pending (Month, Dey Year) 1 2 ☐ Accident Investigation	njury Worl	28c. tnjury et Work? 1 Yes 2 No					
To the Mospital or Attending Physics A hours electrosed. To the Funeral Birds of Start the Compressly filled in by the funeral Medical Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Placa of Injury - At home, fe building, etc. (Specify)	orm, streef, fectory, office	28f. Location (: City or Tou	Street and Number or Rural Route Number, wn, Stete)				
Hospii 74 hours Funeral Firstly filli	29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of exeminetion en end manner stated.							
M Company	29b. Signeture end title of certifier	29c. License		29d. Date signed (Month, Day, Year)				
(1)	Al Tamed Waggo. M.D.	000	52931	MAR 2,1999				
(4)	30. Neme end eddress of person who completed cause of death (Item 23e) A L JAWAD WARAS III/9 Ro KVII	(Type, Print) 1/2 Peke Suit	e 100 Lockvolle	M120852				
State	31. Dete filed (Month, Dey, Year) 32 Registrer's Signeture	6 1 .						

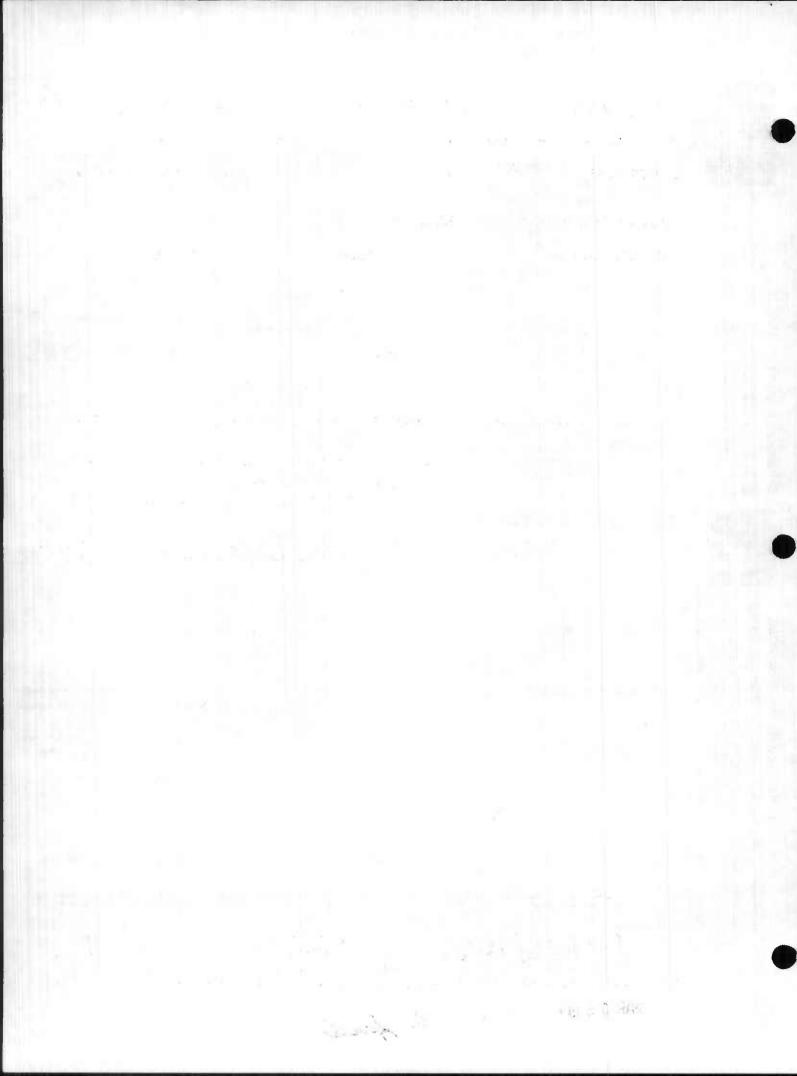
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State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** 1:35 Gm OSChiaVX Virginia 2 26 99 /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Prince George's Hospital Center Prince George's Cheverly If Under 1 Yaar 7. Age (In yrs. last birthday) If Undar 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthpleca (State or Foreign Country) 5 Social Security Number **Funeral** 1 M 2 F Months Deys Hours Min. Yrs. Jan. 5, 1928 Florida 577-30-0787 71 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location 7 is marked other than "naturel", or Items 23s or 28s-f shor traumstic event, the Medical Examinar must be notified at 1 ♥ Yes 2 No Directo Maryland Prince George's Edmonston 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4810 49th Avenue 20781 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armad Forcas? 1 ☐ Yas 2 ☒ No It Yes, Giva Yaar or Datas: Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Raca - Amarican Indian, 11. Maritel Status Bleck, Whita, etc. Pages 1 end 2 should be filed within 72 hours after onent of Heelth and Mental thygiene.
Int: If item 27 ia marked other than "naturel", or item inty or other traumetic event, the Medical Examination. 1 ☐ Navar Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 11 18 Mother's Name (First Middle Meiden Sumema) 17. Fathar's Nema (First, Middle, Last) Be Leroy Hunt Maude (Unknown) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Linda L. LoSchiavo - Daughter 9627 51st Place, College Park, Maryland 20740 20b. Pleca of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stete 20e. Method of Disposition Date 1 ☐ Burial 2 X Cremetion 3 ☐ Removel trom Stata Department of Important: If any injury or pace. 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 02/28/99 Alexandria, Virginia 22. Name and Address of Fecility
Gasch's Funeral Home, P.A. 21. Signeture of Funerel Service Licansee the 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Pert1. Enter the disease, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart teilure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) **Examiner** Examine physician end the buriel-transit that the death certificate be executed Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequenca ot): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequenca of): for use es t Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the causa of death? the signed by the Yas 2 No 3 Probably 4 Unknown by 24b. Ware eutopsy findings available prior to completion of causa of death? Completed 24e. Was en autopsy page 2 has 20 No 1 Yes 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physicien: 24 hours after death. Funerel Director: After this certifica director, Be 25. Wes case reterred to medical examiner? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 28e. Dete of Injury (Month, Dey Year) 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) Pleca ot tnjury - At home, term, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funerel Completely filled Certifying Phyalclan: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steled.

2 Medical Examtnar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steled. 29a. Certifier edical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29a Licensa number Bowie MJ 20 mpleted cause ot deeth (ttem 23e) (Type, Trint)

State Registrar 32. Registrar's Signeture

4000 Mitchell



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\text{9} \) Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month 10:18 am Joseph Gino 1999 LoGiudice Lonery 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Hospital Lanham Prince Georges Community Doctors 5. Sociel Security Number 7. Aga (in yrs. last birthday) If Undar 1 Year | If Undar 24 Hrs. Birthplaca (Stata or Foreign Country) 6. Sax Months Days Hours 1 € M 2 □ F 65 577-44-1070 Nov. 21,1933Messina Italy Usuai Rasidance of Dacedani 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Prince George Lanham 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 9124 6 11. Maritel Status 20706 U.S.A. 14. Hača - Amarican Indien, Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Bleck, Whita, atc. 1 Nevar Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Dacedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondery (0-12) College (1-4or 5+) Ornamental Ironworker Ironworker

18. Mother's Nama (First, Middle, Maidan Surnema) Ironworker 17. Fether's Nama (First, Middle, Last) Anthony Gino LoGiudice Rose Curto 19a. Informant's Neme/Ralationship (Type, Print) 19b. Meiling Addrass (Streat and Number or Rural Routa Number, City or Town, Stete, Zip Coda) 9124 6th Street Lanham Md. 20706

20b. Plece of Disposition (Name of camatary, crematory or other place)

Only of the street Lanham Md. 20706

20c. Location - City or Town, Steta Elizabeth LoGiudice 1 Burial 2 □ Cramation 3 □ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. 3/2/99 Bladensburg Md. Lincoln 21. Signatura of Funaral Sarvica Licansee 22. Nama and Addrass of Facility 9013 Annapolis Road 23a. Part1. Enter the disaesa, or complications that caused the death. Do not anter the mode of dying, such as cardiac of shock, or heart failure. List only one ceuse on each line. Lanham Md. 20706 Approximata Interval Batween Onsat and Death Immadiate Cause (Final disease or condition resulting in death) Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that Initiated avents resulting in death) Lest Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy findings eveileble prior to 24e. Was an autopsy performed? completion of causa of deeth? 1 ☐ Yas 2 ☐ No 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatiant 2 ER/Outpatiant 3 DOA 28c. Injury at Work? 28a. Data of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred

Examiner Box 68760. P.O. Records, of Vital Division

The law requires that the death certificate be executed and buriel-tran eu signed by the e page 2 should After this certificate has

Physician

/Medical

Examiner

Director

by

Completed

Be

Md.

Funeral

Director

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mentel Hygiene.
ant: If Item 27 is marked other than "natural; or Items 23a or 28a-f ehov ury or other traumatic event, the Medical Examiner maint be not used.

permit. Page Department of Important: If any Injury or

Physician /Medical

Logindice, Joseph

replusi or Attending Physicien: The hours efter deeth.

Ineral Director: After this certificate y filled in by the funeral director, pa To the Hospital of within 24 hours of To the Funeral D completely filled i

State Registrar

31. Data filed

Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Completed Be 25. Was casa referred to medical axaminer? 2 1 Yas 27. Manner of Death Certification: 1 Naturel 5 Panding invastigation 1 Yas 2 No 2 Accident 6 Could not be datarmined 3 Suicida 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and piace, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of axamination and/or investigation, in my opinion, death occurred at the time, dete and piace, and due to the cause(s) and manner stated. Medical 29b. Signature and barr of continue

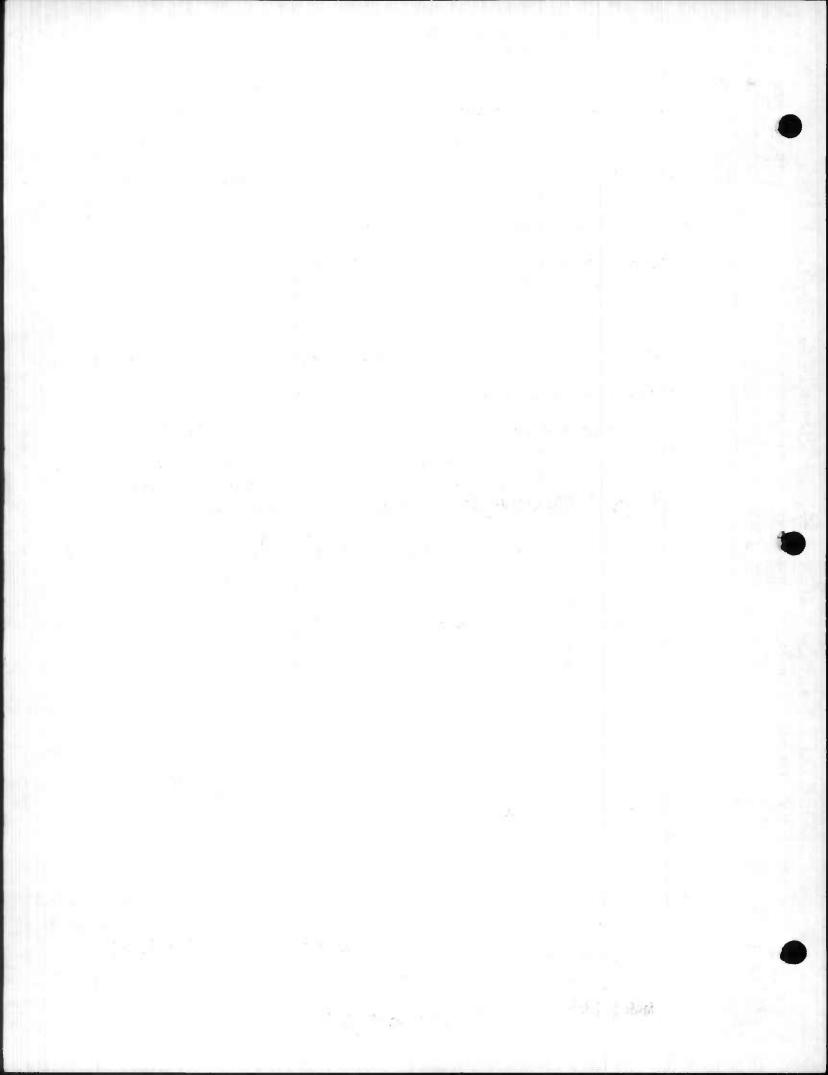
29c. Licanse number

29d. Date signed (Month, Dey, Year)

30. Nema, and address of person who complated cause of death (Item 23a) (Type Print

by Rd. Riverddem 20737

37. Ragistrar's Signature



Please Type or Print in Biack Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			State of Mary		Certificate (Reg. No.	08812	
	Physician	1. Decedent's Name (First, Middle, Las	0				2. Date of De Month		3. Time of Deeth Year	
	Physician /Medical	ALBERT	LITOWSKY	Z			March	1, 1999	9:50 PM	
	Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Deal	th 4c. County of	of Death	
4		Montgomery Genera	L Hospital			Olney ear If Under 24 Hrs		Mont	gomery	
	Funeral	5. Social Security Number 6. Se	7. Age (In	yrs. last birt	Months D			rth ay, Year)	9. Birthpiace (State or Foreign Country)	
	Director	094-12-3602	78	3	rs.		Sept. 2	29, 1920	New York	
	pug *	Usuai Residenca of Decedent 10a, State 10b, County	100	c. City, Town	or Location				10d. Inside City Limits	
	sho sho								1.☐ Yes 2 ☐ No	
	vith the Mer or 28a-f a	Maryland Montgon 10e. Street and Number	nery	Olney	10f. Zip Co	do		10g. Citizen of W	fhat Country?	
	with Die		less II							
	eath	18076 Rolling Mead	12. Was Decedent Ever	in U.S	208:		Specify Yes or N	U.S.A.	- American Indian,	
20	within 72 hours efter death with the Meryland ene. than "natural", or items 23e or 28e-f show ha Medical Examiner must be noticed at empleted by Funeral Director	1 Never Married 2 Married	Armed Forces? 1√Gt/es 2 □ No If Yes, Give		The state of the s	of Hispanic Origin? (S Cuben, Mexican, Puer No Specify:	rto Rican, etc.)	Black Specify:		
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21215-0020	ed within 72 ho ygiene. In the material it, the material Completed	15. Decedent's Ed (Specify only highest grad	de completed)	168.	Decedent's Usual O (Give kind of work d	one during most of wo stired)	orking	TOD. KING OF BUS	Sillessaliquality	
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land	should be filed and Mentel Hygi marked other matic event, I	Charles Litowsky				Kate	Carewsky	,		
Mary		19a, informant's Name/Reletionship (7	ype, Print)	19b.	Mailing Address (Si	reet and Number or R			State, Zip Code)	
M	0 8 2 2			1.80	076 Pollie	Mondoy 1	War Ol-	Morre	10000	
re,	other to	Lillian Litowsky, 20a. Method of Disposition	Wite 2	0b. Piaca of	Disposition (Name of y, crematory or other	ng Meadow	Date	20c. Location - (land 20832 City or Town, State	
no	eges ant of t: if h y or o	1 St Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State			3/0	3/1999	Adelphi	Maryland	
Baltimor	permit. Peges Department of Important: If It any Injury or once.	21. Signature of Fundral Service License	ja J	iount_	Lebanon Co					
Ba	Dep Pen	1 /5 /20	1-11	-		REW MEMOR				
1		23a, Part1 Enter Tile disease, or comp	directions that caused the	death Dor					ON, D.C. 20012	
	Dhamlainn	23a. Part I Enter the disease, or comp shoot or hand failure. List only of	one cause on each line.			-,,			Intervel Between Onset and Death	
	Physician /Medical	Immediate Cause (Final	0 -	- 1		- 1			2	
	Examiner	disease or condition resulting in deeth)	a. Cesis	172	consequence of):	ullope			r cugs	
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	cete be executed physician and s the buriel-transit	Conventially list and disease	b. Voet	2676.	consequence of):	the c		uncer	6 non the	
ć	exec In an riel-tr	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		(0.000						
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of Vital Records,	The law requires the state has been signed page 2 should be d	0.40	2 0	- (1		s an autopsy ormed?	24b. Were autopsy findings evailable prior to	
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Re	he law e has age 2	Remail 2	alone				10	Yes 2500	1 ☐ Yes 2 ☐ No	
ta	certificate rector, pag	25. Was case referred to medical	40 (3 1/2)			26. Place of De	eeth (Check only	,		
>	Physician: this certific ral director, TO Be (examiner?	Hospital:	2□ER/Ou	tpatient 3 DOA	Other	411	sidence 6 Othe	ar (Specify)	
0	g Physer this seral di	27. Menner of Death	28a. Date of Injury (Month, Day Ye	28b. T		Injury et Work?	28d. Describe	how injury occurre	ed	
Ö	ath. After e fur atto	1 Natural 5 Pending 2 Accident investigation	(Monar, Day 10	47	njury M	1 ☐ Yes 2 ☐ No				
Division	Attended by the	3 Suicide 6 Could not be determined	200. Placa of Injury -	At home, fa	rm, street, factory, of	fice		(Street and Number	er or Rural Route Number,	
Ö	tal or Attending P rs efter death. el Director: After t led in by the funera Certification:	4 Nomicide	building, etc. (S	pecity)			Only or 1	omi, otatoj		
	To the Hospital or Attending Physician: The I within 24 hours efter death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page Medical Certification: To Be Com		reicien: To the best of my Iner: On the basis of exa and manner stated.							
	within on the omple	29b. Signature and title of certifier			Annual Contract of the Contrac	cense number		29d. Date signed	1 (Month, Day, Year)	
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	(12)	30. Name and address of person who d	omnieted cause of death	(112) 222	Type Print)			31~1		
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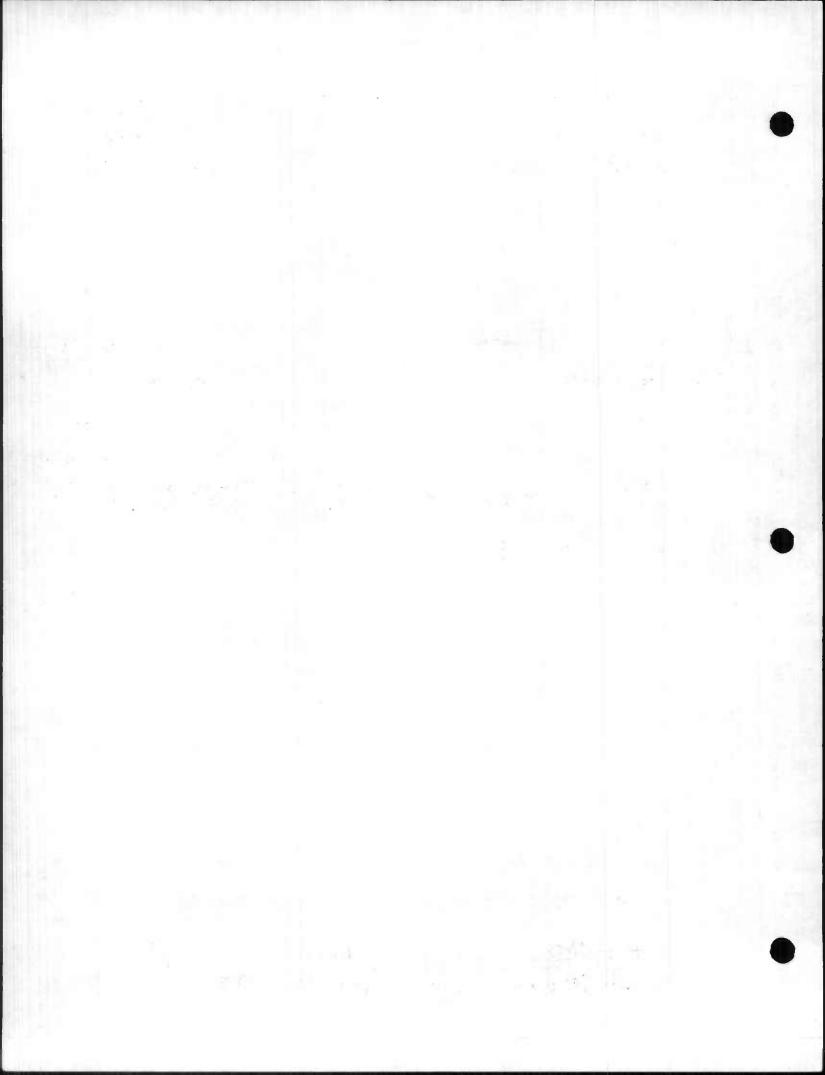
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State of Maryland / Department of Health and Mental Hygiene 9 088 3

			Ce	rtificate of	Death		Re	g. No.			
Dharaisis	Decedent's Name (First, Middle, I			THE STATE OF		2.	Date of Death Month	Day	Year	3. Time of Deal	
Physician /Medical	Margaret Mar	J J				M		6 1999	1001	10:52	PM
Examiner	4a Facility Name (M not institution, g Waldorf Healt	ive street and number) hcare				own, or Locat dorf		4c. County of Char	100		
Funeral Director	5. Social Security Number 202-42-4046	Sex 1 M 2 X F 96	rs. last birthday Yrs.	Months Days		Min. 8.	Date of Birth (Month, Day, an . I	Year) 1903	9. Birthple Count	ace (State or Formy)	eign
p .	Usual Residence of Decedent 10a. State 10b. County	100	City, Town or L	ocation					1	d. Inside City Lin	nito
er death with the Maryla here 28s or 28s-f sho ner must be notified at 'umeral Director	MD Charl		laldor	E				1		1 Ves 2	
h with the 25s or 2 set be no	10e. Street and Number 4140 Old Washi	ington Road	ton Road 20601					g. Citizen of W USA	/hat Country?		
ers at	11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	U,S. 13.	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 Yes 2 No Specify:					ce - American Indian, ck, White, etc. y: White		
42 should be filed within 72 hours at a should be filed within 72 hours at a should be filed than "natural", or traumatic event, the Medical Exam To Be Completed by I	15. Decedent's (Specify only highest of		16a. Dece	dent's Usual Occu	pation	at of working	1	6b. Kind of Bus	siness/Ind	ustry	
mple Men	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	ed)	a or working		Public School		1 0-	
Be som	12 17. Father'a Name (First, Middle, La Martin Mahady	şt) <u>(</u>	Scho	ool Tead	18. Mothe			laiden Sumame		noor S	ys.
thould the marks marks marks To	19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Stree			-	-	State. Zip (Code)	11-11
alth a 27 is r tra	Ann S. Busser			Mitche							
mit. Pages 1 a partment of He portant: if Isem y Injury or othe 68.	20a. Method of Disposition 1 Disposition 2 Cremation 3 4 Donation 5 Other (Special Control of the Control of	DRemovel from State	. Placa of Disp cometery, cre	osition (Name of ornatory or other place in the character)	ica)		Dete 2	Oc. Location - (City or Tov	vn, State	ani
permit. Departminimporta any inju	21. Signature of popular Service Lice	/ /	1	2. Name and Addr AREHART -	FCHO	TC FI	JNERAL	HOME	P.A	•	
	23a. Part1. Enter the disease, or co shock, or heart failure. List on	molications that caused the de	esth Do not en	e O BOX	567	LA F	PLATA,	MD 20	0646	Approximate	
Physician	shock, or heart failure. List on	y one cause on each line.	Sain. DO NOT GO	no mode or dy	ing, such ba	Cardiac of 1	sapiratory arro	οι,		Interval Between Onset and Death	1
/Medical	Immediata Cause (Final	Back	- Cos	w						hele	
Examiner	disease or condition resulting in death)	a. Due to							17	VAS	
D 5	Due to (or as a consequence of): b. Sequentially list conditions, if any, leading to immediate cause. Enter Underwing.										
death certificate be assected e attending physician and of for use as the burial-transit sician/Medical Examines											
Man M	thet initieted events resulting in death) Last	Due to									
at the death ce d by the attendi etached for use Physician/	Part II. Other significant conditions	contributing to death but not n	1.	23b. Did tobacco use contribute to the cause				ath?			
							1 □ Ya	a 2 No	3 Prob	ably 4 Unkr	nown
aw requi					STEV I		24a. Wes an perform		con	re autopsy findin- ilable prior to apletion of cause eath?	
The i							1 🗆 Yes	s 2 No	1 🗆	Yes 2 No	
ysician: The sectificate director, page Co	25. Was case referred to medical examiner?					a of Death (C	Check only one)			
His Pis	1 Yes 2 No		☐ ER/Outpatie	nt 3LI DOA		- 1		nce 6 Othe)	
eath. or: After the fune	27. Manner of Death 1 Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could not		28b. Time of Injury	Wo	ry at ork? Yes 2	No		w injury occurre			
lal or Attending is after death. In Director: After ed in by the fune Certification	4 Homicide determine		nome, farm, si city)	reet, fectory, office		28f.	. Location (Str City or Town,	eet and Numbe State)	er or Rural	Route Number,	
Hospi 4 hour Funer tely fill											
within 2 To the comple	29b. Signature and title of certifier			29c. Licen	se number		29	d. Date signed	(Month, E	Pay, Year)	
	1 HHAW			DX7348 3/9/RZ							
	30. Name end address of person wh	completed cause of death (It	tem 23a) (Type	Print)	١٨٨١	20	302	7011			
	31. Date filed (Month, Day, Year)	32. Registrar's Sig	es U	A COLT	100	CUI	su_				
State Registrar	MAR 09	- /		. Loon	Kal						



MOOREHEAD, THOMAS R. SR.

		Please Type or P State of		/ Depa	rtment of H	lealth an	e All Copies d Mental Hy	-	ble.
		Item:8 per F.H G-769 3/23/99 re	b	Cen	tificate of	Death		Reg. No.	00014
1 5		Decedent's Neme (First, Middle, Last)					2. Deta of De		3. Time of Death
Physic		THOMAS RICHARD MOORE	HEAD CI	D			Month March O	Dey 5. 1999	3:47PM
/Med Exami		4e. Fecility Neme (If not Institution, give street end numb				4b. City, Town,	or Location of Death		
LAGIIII	IIICI	Cininto Modical Conton				T - D1 -		Cham1	
Funeral		Civista Medical Center 5. Social Security Number 6. Sex 7.	. Age (In yrs. last	birthday)	If Undar 1 Yaar	La Pla	Hrs. 8, Date of Bird	Charl	9. Birthpieca (State or Foreign
Director		236-03-3982 XDM 2DF	80	Yrs.	Months Deys	Hours	Hrs. 8, Date of Bin (Month, De L'EDTUATY	25 191	
		Usual Residence of Decedent	0.0						
yten wow		10e. Stete 10b. County	10c. City, T	own or Loc	ation				10d. Inside City Limits
Mar	tor	MD Charles	La Pi	lata					1 ☐ Yes 2 ☐ No
permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other treumstic event, if a Medical Examination mant be notified at an optice.	Funeral Director	10e. Street end Number			10f. Zip Code			10g. Citizen of V	Vhat Country?
3a o	0	6080 Hannon Drive			20646			TICA	
The 2	Jera	11 Marital Status 12. Wes Decede	ant Evar in U,S.	13. W	20646 as Decedent of F		? (Specify Yes or No uerto Rican, etc.)	USA 14. Raci	e - American Indien,
the the	Fur	1 Never Married 2 Married 1 Yes 2	UNT JAT.		77		uerto Rican, etc.)	Blac	k, White, etc.
d within 72 hours ef gjene. ir than "natural", or	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give	10/5	1	☐ Yes 2 No	Specify:		Specify	. White
2 hou	8	15. Decedent's Education	1	6a. Decede	ent's Usuel Occup	pation		16b. Kind of Bu	isiness/Industry
Z uin Z	pie	(Specify only highest grade completed)		(Give k	ind of work done O NOT use retire	during most of d)	working		
with liene.	Completed	Elementery/Secondery (0-12) College (1-4	I F	Route	Manag	er		Newspa	aper
Hygi Hygi ent, tr	BeC	17. Fether's Neme (First, Middle, Last)				18. Mother's	Neme (First, Middle,		•
nd 2 should be filt th end Mental Hy 27 Is marked oth trsumatic event	ToB	Lee Roy Moorehead				Emma	Mae Bus	h Moore	ahoad
mar mar	1	19e. Informent's Name/Reletionship (Type, Print)		19b Mailing	Address (Street		r Rural Route Number		
d 2 st er 7 le treu		Rose Moorehead/Wife						-	
1 and Heelth		20eMethod of Disposition			ition (Neme of	DITAE	La Pla		City or Town, Stata
Pages nent of int: If ite		A Burial 2 ☐ Cremetion 3 ☐ Removel from Str	ate cem	etery, crem	etory or other ple	,			
vermit. Pages 1 a Department of Hee mportant: if Item in Iny injury or othe		4 Donation 5 Other (Specify)	Mary1	land	Vetera	ns Cen	1.3/12/9	9 Chelt	enham, MD
permit. Pag Department Important: I any injury o		21. Signeture — unerel Service Licensee		22.	Neme and Addre	ess of Fecility			
80559		Charil M. al.	Manage	AN	C POY	ECHOLS	FUNERAL	L HOME	
		23a. Pert1. Enter the disease, or complications that cau shock, or heart feilure. List only ona cause on each	ised the deeth. I	Do not enta	r tha moda of dyl	ng, such as car	A PLATA	, MD 20	Approximete
Physician		shock, or heart fellure. List only one cause on each	ch line.						Interval Between Onset end Death
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Examiner		disaesa or condition resulting in death) e.	llehon	nuch	Marin	120	ssouale	ela	
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nsit	Examiner	b.	Milita	ا لا	ardia	jazin	they		
e executed ian end uriel-transit	Xa	Sequentially list conditions, if eny, leading to immediate	Due to (or es	e consequ	ence of):	0 0			
be ex ician buriel	1	ceuse. Enter Underlying Ceuse (Diseese or Injury							
The law requires that the death cartificete be executed to has been signed by the ettending physician end page 2 should be deteched for use as the buriel-transit	Physician/Medica	thet Initieted avents resulting in deeth) Lest	Due to (or as	a consequ	ence of):				
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ttend or us	lan								
at the death certificete by by the ettending physics steched for use es the bates has been at the bates at th	S	Part Ii. Other significant conditions contributing to deat	h but not resultin	g in the un	darlying cause give	ven in Pert I.	23b. Did	tobacco use cor	ntribute to the cause of death?
uires that the dei signed by the e	Ph	(O P O E	- 0		17	1	() 10	Yes 210 No	3 Probably 4 Unknow
gned be d	by	Share Rund	autu	La	2 0 1	when	الم		
he law requires the law								en eutopsy rmed?	24b. Were eutopsy findings eveileble prior to
w requ	Completed	Mulyes					perio	illied i	completion of cause of deeth?
e hes	E	0					10)	Yes 2 10	
icate or, pa	Ö	OF Management and the second s					10'		1 ☐ Yas 2 ☐ No
or Attending Physician: The isfer death. Director: After this certificate he is the funeral director, page	00	25. Wes cese referred to medical exeminer? Hospital:			O#	205	Deeth (Check only of		
Physician: rthis certific and director,	2	1 10 105 2 1 1 1 1 1 np			OL DON	4 L 14013#	ng Home 5 Resk		
After After funer	on	27. Manney of Deeth 26a. Dete of \\ 1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Day Year) 28	b. Time of Injury	28c. Inju			how Injury occurr	ed
Attending Isr deeth. ector: After by the funer	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No			
or Attende effer deetl Director:	Certification:	3 Suicida 6 Could not be determined 28e. Piace of building	Injury - At homa, etc. (Specify)	, farm, stre	et, fectory, office		28f, Location (S City or Tox		er or Rural Route Number,
o to le	Cel								
To the Hospital or within 24 hours efte To the Funeral Dir completely filled in		29e. Certifier 1 Certifying Physician: To the best	est of my knowled	dge, death	occurred et the ti	me, dete end p	lece, end due to the	ceuse(s) end me	nner es stated.
n 24 n 24 plete	edicai	(Check only 2 Medical Examtner: On the basi one) 2 Medical Examtner: On the basi end menner		enavor inve	stigation, in my o	ppinion, deeth o	occurred et the time,	dete end piece, o	end due to the ceuse(s)
withi To th	Σ	29b. Signeture end title of certifier			29c. Licens	se number		29d. Data signed	(Month, Dey, Year)
		7 Jm L 1	7 1.		D 010	00		3-5	7-99
		30. Name end eddress of person who completed cause of	of death (Item 22	(A) (Type D	D-010				
		Henry Burke, MD 115 A	La Gra	nge I	Ave. La	Plata	a,MD 206	46	

DHMH 16 Rev 6/95

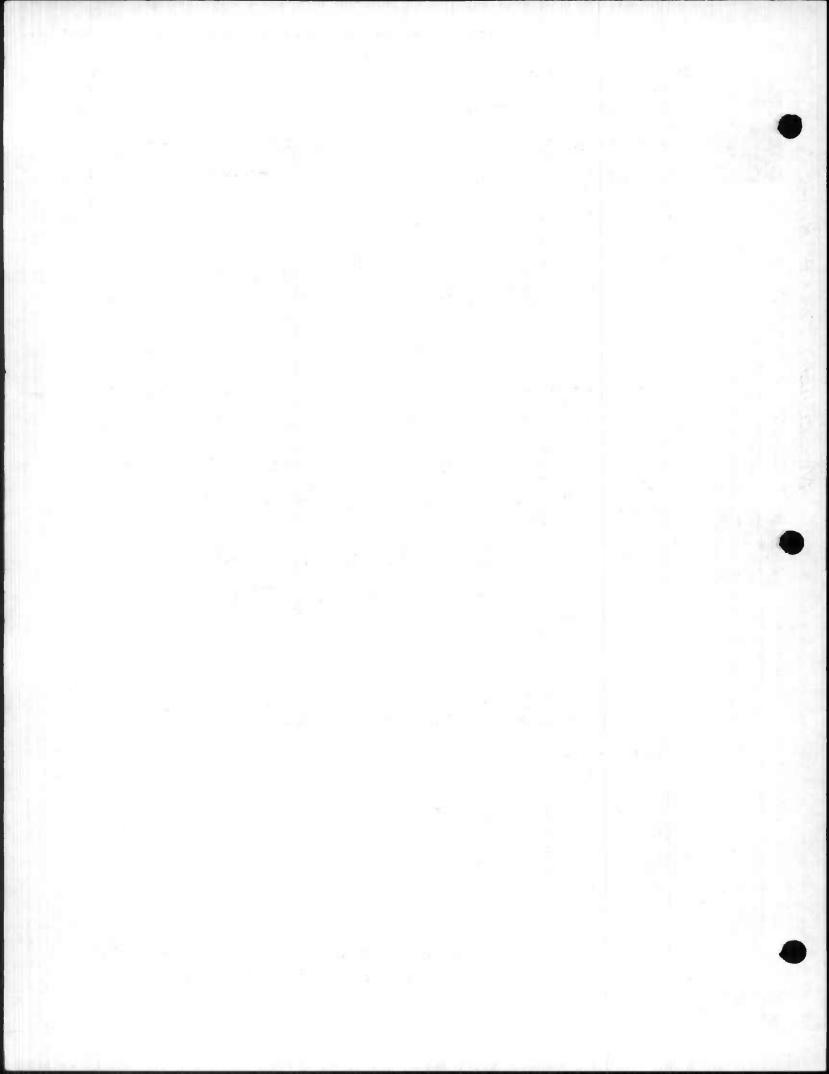
State

Registrar

31. Dete filed (Month, Dey, Year)

32. Registrer's Signeture

Sporks



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death F F.B Day 999 28 0500 VERONICA MASON 4e Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 5 Social Security Number 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign Deys 1 M 2 F Yrs MARYLAND FEB. 6 1951 16-60-5325 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND ANNE ARUNDEL ANNAPOLIS 1 XYes 2 No 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? 21401 US 702 K. NEWTOWN DRIVE 14. Race - American Indien. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status Bleck, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Merried 20 Merried 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOME HOUSEWIFE 12th 18. Mother's Name (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Last) VIVIAN BLAKE RALPH M. HOLLAND 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 702 K. NEWTOWN DR. ANNAPOLIS, MD. 21401 JAMES MASON (HUSBAND) 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify) ANNAPOLIS MEM. GARDENS 3.5.99 ANNAPOLIS, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility REESE ST. SONS MORTUARY MD. P24401 eese 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onaet end Deeth Immediate Ceuse (Finel disease or condition resulting in deeth) Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of) Due to (or es e consequenca of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings sveilable prior to 24a. Wes an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one)

Physician /Medical Examiner

Examiner

Physician/Medical

by

Completed

Be

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Certification:

Medical

29b. Signeture end title of cartifier

Physician

/Medical

Examiner

Director

Funeral

à

Completed

Funeral

Director

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238

traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental hygiene. Important: If item 27 is marked other than "naturel", or item any injury or other traumatic event, the Medical Examines once.

Baltimore, Maryland 21215-0020

with the Maryland

death Heme

> physician and s the burial-trans USB signed by the a d be detached f has page 2

certificate be executed Mospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical. funeral director, filled in by

Division of Vital Records, P.O. Box 68760

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 25. Wes case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be determined 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homlcide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29e. Certifier (Check only one)

29c. License number

Registrar

100 Mill DEETY AUESTE IN ANNAPOUS MA

29d. Dete aigned (Month, Dey, Year)

To the Hosp within 24 ho To the Fune completely fi

programme and the second

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth 25, KATHRYN ANNE McVEIGH FEB. 2:50 AM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS 8. Date of Birth (Month, Day, Year) JAN. 15, 1920 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) OHIO 5. Social Security Number 7. Age (In yrs. last birthday) 1 M 2 XF Months Deys Hours Min 79 Yrs. 272-18-0482 Usuai Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3015 EAST FRIENDS ROAD 21401 UNITED STATES 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 N Married Specify: WHITE 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 12 0 AT HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) WADE PATTON ETHELYN PFEIFFER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDWARD McVEIGH (HUSBAND) 3015 EAST FRIENDS ROAD ANNAPOLIS, MD. 21401 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, Slele 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03-01-99 HILLCREST CEMETERY ANNAPOLIS.MD. 22. Name and Address of Fecility JOHN M. TAYLOR FUNERAL HOME, INC. 147 DUKE OF GLOUCESTER ST. ANNAPOLIS, MD. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete intervei Between Onset and Death pneumonia Iday immediate Cause (Final disease or condition resulting in death) myeloma multiple Due to (or as a consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Last Due to (or es e consequence of) 23b. Dfd tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 1□ Yes 20 No

Physician /Medical Examiner

Examiner

Physician/Medicai

à

Completed

Be

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Certification:

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

5 Pending investigation

6 Could not be determined

permit. Pages Department of Important: If it any injury or o

Physician

/Medical

Examiner

10a State

Directo

Funeral

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Completed

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland neet of Health and Mental hyglene.

Int: If Item 27 is marked other than "naturel", or items 23s or 28s-f show that if you have a supplementation of the promised and any or other traumatic event, in Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

that the death certificate be executed physician end the buriel-transit 88 use use ŏ signed by the a d be datached f i certificata has t director

Division of Vital Records, P.O. Box 68760, or Attending Physician: this funeral After death. ector: To the Hospital or A within 24 hours after To the Funeral Directorn plately filled in by

> State Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 290. Signature and title of certific 29c. License number uilly u.o.

28c. Injury at Work?

30 Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

1 Yes 2 No

Bestoak Rd. Aunapolis, Ud. 21401

28f. Location (Street and Number or Rural Route Number, City or Town, State)

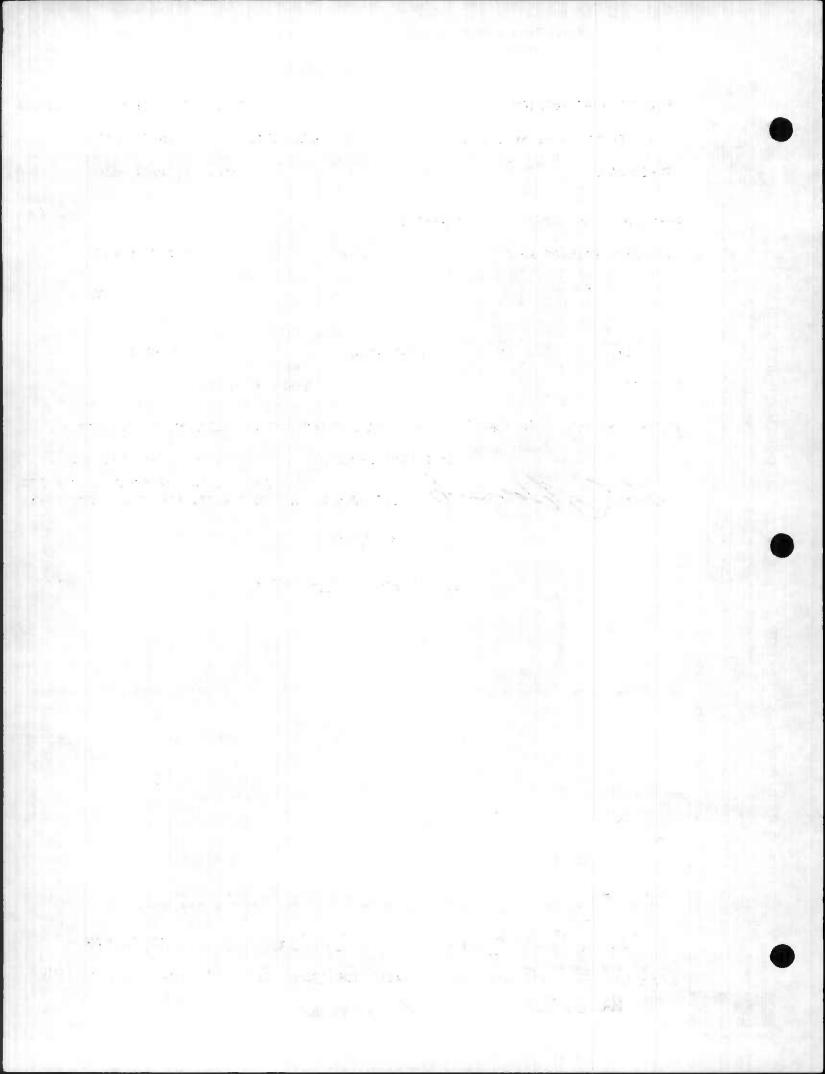
28d. Describe how injury occurred

32. Registrar's Signature

28a. Date of fnjury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Deeth 3. Time of Death Month **Physician** Feb. Stephen Anthony Muse 26, 1999 12:35PM /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 386 Yorkshire Lane Anne Arundel Hours Min. 8. Dete of Birth (Month, Day, Year)

April 24, 1961 If Under 1 Year Birthpiece (State or Foreign Country)
 New York 5. Social Sacurity Number 7. Age (In vrs. lest birthday) **Funeral** Deys 1 M 2□ F Months 214-88-9793 37 Yrs. New Director Usuel Rasidanca of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic event, it a Medical Experiest must be notified at once. 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 No Maryland Anne Arundel Directo Riva 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 386 Yorkshire Lane 21140 United States Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 Ñ No If Yes, Give Yeer or Detes: 14. Race - American Indian, Bieck, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Merried 2 Married Specify: White 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedant's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Eiamantary/Secondary (0-12) Collage (1-4or 5+) Self Employed Landscaping 18. Mother's Neme (First, Middle, Maidan Sumama) 17. Fathar's Nema (First, Middla, Last) Elizabeth A. Riggs Jude T. Muse 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stata, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 386 Yorkshire Lane, Riva, MD Elizabeth A. Muse (Mother) 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Slete 20a. Mathod of Disposition 1 ☐ Burial 2 Cremetion 3 ☐ Remove from State Ft. Lincoln Crematory 3/1/99 Brentwood, Maryland 4 □ Donetion 5 □ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signeture of Funerel Service Ligant 147 Duke of Gloucester St. Annapolis, MD 21401 m 23a. Pert1. Entar tha disaase, or complications thet caused the death. Do not enter the moda of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset end Deeth **Physician** Immediete Cause (Final diseese or condition resulting in daath) /Medical **Examiner** the CNS Examiner physician end s the buriel-trensit The law requires that the deeth certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury lhet initiated events rasulting in death) Lest Division of Vital Records, P.O. Box 68760 Physician/Medical ettending p for use es 80 ed by the e 23b. Did tobacco usa contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 20 No 3 Probably 4 ☐ Unknown 1 Yes signed t by 24b. Wara autopsy findings eveilable prior to been sig 24a. Was an autopsy performed? Completed compiation of causa of daeth? page 2 s hes 1 ☐ Yas 2 ☐ No certificate director, or Attending Physician: 25. Wes case raferred to medical exeminer? Be 26. Place of Death (Check only ona) 1 Yes Other: 4 Nursing Home Certification: To 1 ☐ Inpalient 2 ☐ ER/Outpatiant 3 ☐ DOA 5 Residanca 6 □Other (Specify) this 28d. Describe how injury occurred After thi 28c. Injury et Work? 27. Manger of Deeth 28b. Time of 28a. Data of Injury (Month, Day Year) 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yas 2 ☐ No death. within 24 hours after death To the Funeral Director: , completely filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide Hospital 29e. Certifier 🔁 Certifying Physician: To tha best of my knowledga, daeth occurred et the time, dete end piece, and due to the ceuse(s) end mannar as stated edical 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daeth occurred et tha tima, data and place, and dua to the cause(s) end mennar stated. (Check only one) To the P within 2 29d. Date signed (Month, Day, Year) rello w medical 00001094 of person who completed cause of deeth (Item 23a) (Type, Print)

H. MD (200 N. Wolffe St. Ma

32. Regi grar's Signeture

State Registrar

BERT TILL HAM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Deta of Daath 3. Time of Death **Physician** 09/1 26 /Medical City, Town/ or Location of Death 4a. Facility Nama (If not institution, giva street and number 4c. County of **Examiner** TNNA 0415 If Undar 1 Yaar If Undar 24 Hrs 8. Date of Birth (Month, Day, Year) Warch 30, 1915 5. Sociei Security Numbe 6 Sax 7. Age (In yrs. lest birthday) 9. Birthplaca (Stata or Foraign **Funeral** 1□M 2XF Deys Mary land 217-03-9627 83 Yrs Director Usuel Residence of Dacedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1933 Fairfax Road 21401 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yas, Giva Yeer or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bieck, White, atc. 11. Maritei Stetus permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or then sny Injury or other traumeth as and Injury or other traumeth as a supplication of the Injury or other traumeth as a supplication of the Injury or other traumeth as a supplication of the Injury or other traumeth as a supplication of the Injury or other traumeth as a supplication of the Injury or other traumeth as a supplication of the Injury or other traumeth as a supplication of the Injury or other traumeth as a supplication of the Injury or other traumeth as a supplication of the Injury or other trange or other traumeth as a supplication of the Injury or other t 1 Nevar Marriad 2 Merried 1□ Yes 2☑ No white Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Spacify only highast grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiamentery/Secondary (0-12) College (1-4or 5+) Homemaker own home 17. Fethar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Melden Sumema) Osborne Lewis Grimstead Lillian May Davenport 2 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) James O. Bacon (nephew) 1933 Fairfax Rd. Annapolis, MD 21401 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☑ Buriai 2 ☐ Cremetion 3 ☐ Ramovel from State Springfield Cemetery 3/1/99 Sykesville, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funaral Service Licensee 22. Name and Addrass of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Pert1. Enter the disaase, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disaase or condition resulting in deeth) Examiner Examiner physician and s the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): 88 esn jo detached Pert ii. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributa to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy tindings aveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed page 2 1 ☐ Yas 21 No 1 ☐ Yes 2 ☐ No 25. Wes casa reterred to medical axaminar? Be 26. Piece of Deeth (Check only ona) Hospitei: Other: Nursing Home 5 Residance 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 1 Dinatural 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yas 2 No 2 Accidant 6 Could not be determined

Box 68760. Division of Vital Records, P.O.

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To the Funeral Director: Afte completely filled in by the fun

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Baltimore, Maryland 21215-0020

State Registrar

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Signeture and title of certific

28a. Piece ot injury - At home, farm, streat, tactory, office building, etc. (Specify)

1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Madical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Straat and Number or Rural Route Number, City or Town, Steta)

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Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month FEB. FLONNIE MACK 1999 21 3:30 pm 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death ANNE ARUNDEL MEDICAL CENTER | ANNAPOLITIES | ANNAPOLITIES | ANNAPOLITIES | ANNAPOLITIES | B. Date of Birth (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Year) | P. Birthpe (Month, Dey, Ye ARUNDEL 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Months 1 M 2 F 214-14-8257 84 Yrs. CAROLINA Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits MARYLAND ANNE ARUNDEL SEVERNA PARK 17 Yes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 914 BALTIMORE & ANNAPOLIS BLVD. 21146 US 12. Wes Decedent Ever In U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indien Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: BLACK 3X Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th SELF EMPLOYED RESTAURANT OWNER 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) JOHN D. LASSITER MAMIE SANDERS 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 2 1 7 7 6 19e. Informent's Neme/Reletionship (Type, Print) 1128 WESTERN CHAPEL RD. NEW WINDSOR, BURTON L. MACK (SON) 20b. Plece of Disposition (Name of cemetery, crematory or other p 20c. Location · City or Town, Stete 20e. Method of Disposition Dete CARPENTER HILL *Buriel 2 Cremation 3 Removal from State CEME. 2/27/99 ROUND BAY, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signefure of Funerel Service Licensee 22. Name and Address of Fecility WM. REESE & SONS MORTUARY, P.A. A. Reese Age 821 WEST ST. ANNAPOLIS, MD. 21401

23a. Pert1. Enter the disease, or combilications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart finiture. List only one cause on each line. Approximate Interval Between Onset end Deeth Cardio Pulmonary arrest Immediate Cause (Finel disease or condition resulting in deeth) arteril selesostie i c Caroliousseulas Due to (or es e consequence of): Due to (or es a consequence of): 23b. Did tobecco use contribute to the cause of deeth? Pert it. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Wes en eutopsy 1 Yes 2 No 1 □ Yes 2 □ No

Physician /Medical Examiner

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Division of Vital Records, P.O.

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altimore, Maryland 21215-0020

Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lesf

5 Pending Investigation

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Manner of Deeth

1- Naturel

2 Accident

3 ☐ Suicide

28e. Dete of Injury (Month, Dey Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

6 Could not be determined 4 Homicide 29a. Certifier

28e. Plece of injury - At home, ferm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manger stated. (Check only one) 29b. Signature/and title of certil

29c. License number D08293 29d. Date signed (Month, Day, Year) 02 25 99

ath (Item 23a) (Type, Print)

DONALD HISLOP, M.D. 31. Dete filed (Month, Day, Year)

MAR 0 1 1999

31 32. Aegistrar's Signature

ROBINSON RD. SEVERNA PARK, MD. 21146

26. Plece of Deeth (Check only one)

Registrar

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 0 0 0 0 0

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State Registrar

31. Date filed (Month, Day, Year) MAR 05 1999

Mohammad Rahman, M.D.

29b. Signature end title of certifier

32. Registrer's Signeture

Dr. M. A. Rehman, MD)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

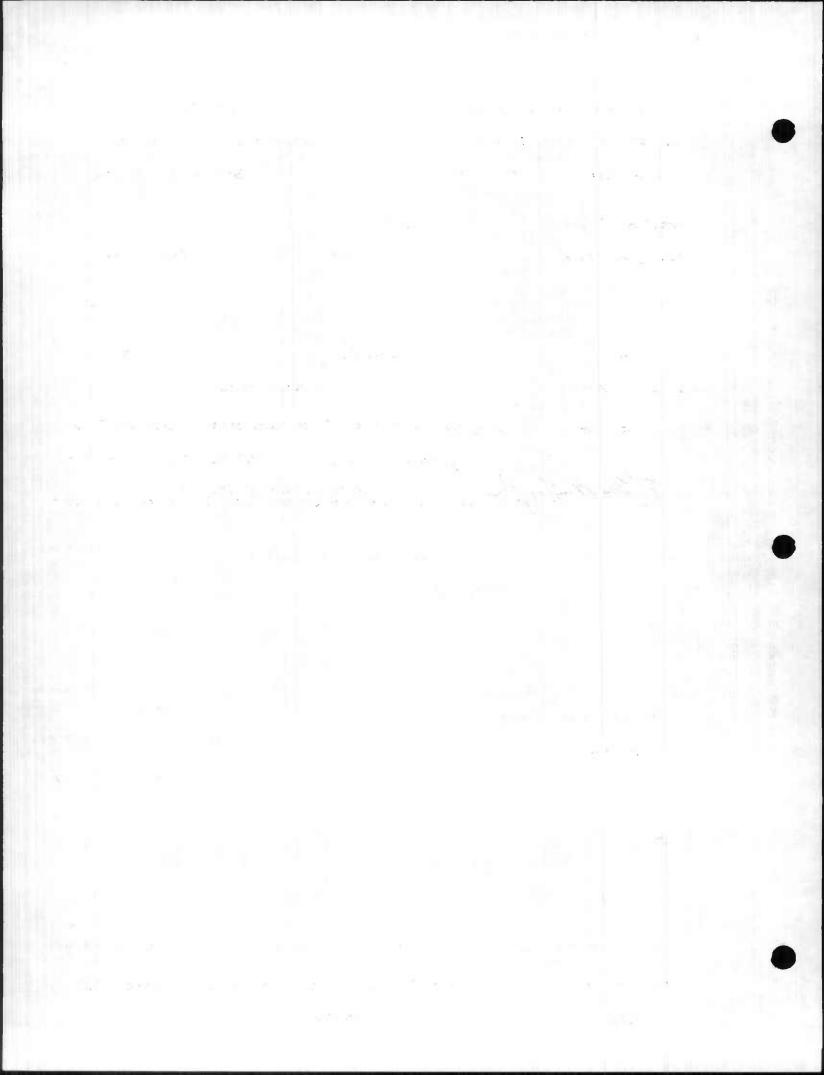
29c. License number

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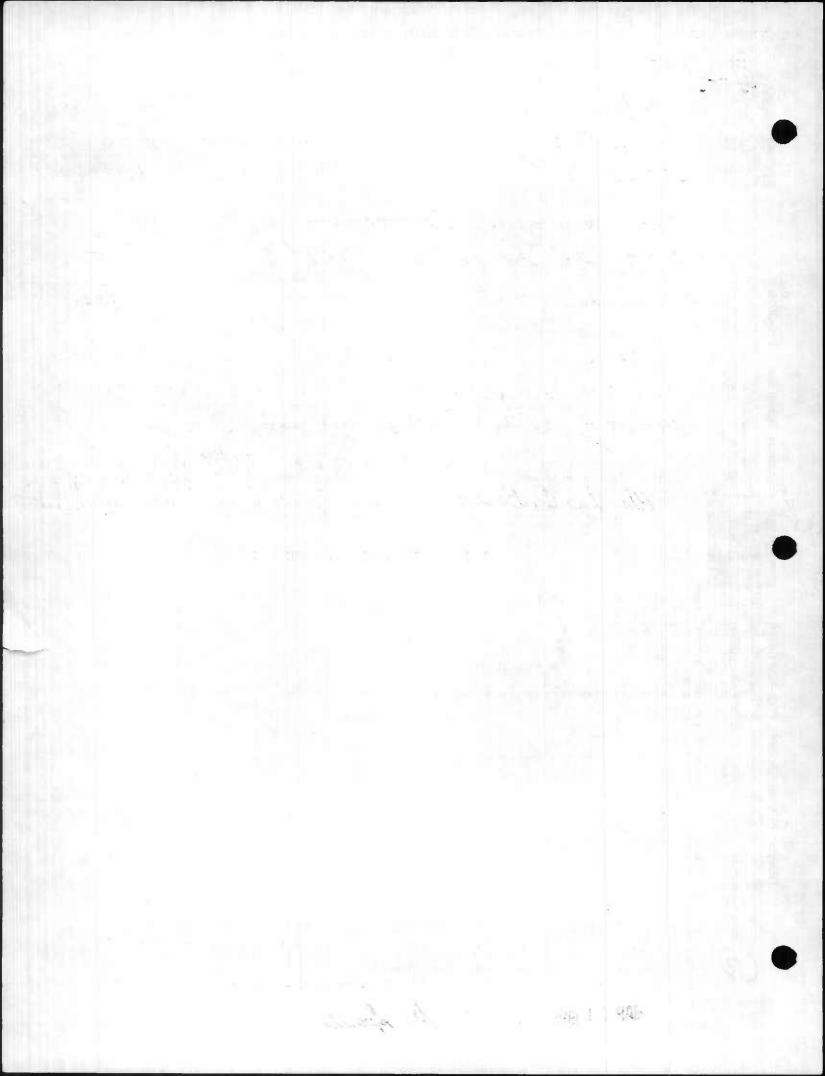
24035 Three Notch Road, Hollywood, Maryland 20636

29d. Date signed (Month, Dey, Year)

March 04, 1999



ADH	2 Plance Type or Print in Plack Indelible ink. Accure All	Conles Are Legible
ANTHONY MARCUS 99-1285-033 ITEMS: #2	State of Maryland / Department of Health and Me	
Amenditem	1. Decedent's Name (First, Middle, Last) 2. PART i 127 RER MED 6769 3-26-99 WR C Certificate of Death 1. Decedent's Name (First, Middle, Last)	Reg. No. 3. Time of Death
Physician	A. Han 1/10000	Month Day Yeer
/Medical Examiner	4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Loca	MARCH 7, 1999 0845 AM
Examiner	5004 LEE JAY DRIVE CAPITOL HE	IGHTS PRINCE GEORGES
Funeral	Months Days Hours Min.	Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Director	Usual Residence of Decedent	AACH 16 1948 WAShinggo, DC
ylend	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
death with the Marylend rms 23a or 28a-1 show Livust be notified at neral Director	MD Howa Georges Forestville Capi	to Heights 1 Yes 2 1 No
with the Ma	10e. Street and Number	10g. Citized of What Country?
eath w	11 Marital Status 12 Was Decedent Ever In U.S. 13. Was Decedent of Hispanic Origin? (Specific	v Yes or No-
j 22 j	1 Never Married 2 Married 1 Yes 2 No	an, etc.) Black, White, etc.
21215-0020 within 72 hours etter ene. Men'reaturel;, or fite the Menical Examine ompleted by Fu	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	specify: Dlack
21215-00; ed within 72 hours ygiener than "naturel; ft, the Medice Ex Completed b	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired)	16b. Kind of Business/Industry
212- 1 withir piena.	Elementery/Secondary (0-12) College (1-4or 5+)	Hospital
and 2 be filed and other event, II	1214	First, Middle, Maiden Sumeme
aryland 2 should be filed should be filed marked other unatic event, I	William herox Marcus Dolore	S ITENE Brown
01 00 00 00	19a Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural I	Poure Number, City or Town, State, Zip Code) 20903
	20a. Method of Disposition 20b. Plece of Disposition (Name of	Date / 20c. Location - City or Town State
2 8 2 = 2	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery crematory or other place)	ulga Arlinaton VA
프 교육원을	21. Signature of Funeral Service Licensee 22. Name and oddress of Facility	3447 SHT ST 1111
Bal Bal Bal Bal Bal Bal Bal Bal Bal Bal	Manda C. Bacon BARN FINERO AN	no Washington AC 10010
	23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or shock, or heart feilure. List only one cause on each line.	espiratory arrest, Approximate Interval Between
Physician		Onset end Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	
uted ansit	Due to (or as a consequence of):	
	Sequentially list conditions, Due to (or as a consequence of):	
60, be axect cian end ourial-tra	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): c	
S87 icete licete l	that initiated events Due to (or es e consequence of): resulting in death) Last	
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ds, P.O. Berries that the death signed by the atte d be detached for d by Physicia	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.	23b. Did tobacco use contribute to the cause of death?
P.C at the d by th betach		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
ds, signed be deby		24a. Was an autopsy 24b. Were autopsy findings
cord v requir been s should		24a. Was an autopsy performed? 24b. Were autopsy findings evailable prior to completion of ceuse of deeth?
Il Record The law requir ate hes been si page 2 should		18 Yes 2 No 1 Yes 2 No
f Vital Raysiclan: The Laysiclan: The Laysiclan director, page	25. Wes cese referred to medical examiner?	
of V hysic his ce al direc	1XX es 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	S S Residence 6 □ Other (Specify)
Ing P. J. After t	1 (Natural 5 Pending (Month, Dey Year) Injury Work?	d. Describe how injury occurred
Division of Vital Records, or attending Physician: The law requires the death. Director: After this certificate hes been signed in by the funeral director, page 2 should be certification: To Be Completed by	3 Sulcide 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office 28	f. Location (Street and Number or Rural Route Number,
Division c tal or Attending P rs after death. si Director: After it ed in by the funers Certification:	4 ☐ Homicide building, etc. (Specify)	City or Town, Stele)
Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica complataly filled in by the funeral director, Medical Certification: To Be (29a. Certifier (Check only one) 1 Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and place, an check only one) 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred and menner stated.	d due to the cause(s) end menner as stated. at the time, dete end plece, and due to the ceuse(s)
within 2 or the compla	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
	Mounte Prellale pm OCME	MARCH 8, 1999
(2)	30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)	
	M/Sugnato Com 111 Penn Street, Baltimo	ore, Maryland 21201
State Registrar	31. Date filed (Month, Day, Year) MAR 1 1 1999 See Registrar's Signature	



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death

111 Penn Street, Baltimore, Maryland 21201

1. Decedent's Name (First Middle Last) 2. Dale of Death 3. Time of Death Month FEBRUARY 28, 1999 **Physician** 1015 AM Teresa R. Mundine /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 3203 REED STREET GLENARDEN PRINCE GEORGES 8. Date of Birth (Month, Dey, Yeer) Sept 19,1964 If Under 1 Year | If Undar 24 Hrs. 9. Birthpleca (State or Foreign Country) 4. Virginia 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Months Days Hours Min 1 M 2 XF Yrs. 238-38-0802 34 Director Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. Cify, Town or Localion 10d. Inside City Limits "natural", or items 23a or 28a-f ehow 1 Yes 2 No Prince Georges Capitol Heights Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 1419 Nova Ave 20743 U.S.A. Pages 1 and 2 should be filed within 72 hours efter deeth neat of Health and Mental Hygiene.
Instit If Hem 27 Is marked other than "natural", or flems 23 mr, if Hem 27 is marked other than "natural", or man arry or other traumatic event, in a Medical Engine or man. Funeral 12. Wes Decedenf Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give ** Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian. 11. Marilel Status Bleck, Whita, atc. 1 Naver Married 2 ☐ Married 1 Yes 2 No Specify: Specify: Black P 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Cashier Retail Store 12 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Lest) Be Mary Francis Mundine James Lee Hobbs 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 406 Main St Emporia, VA 23847 Moses Mundine Brother 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition permit. Peges Department of Important: If It eny Injury or o 1X Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 3/6/99 Franklin, VA. Southview Cemetery 22. Name end Address of Fecility Central VA Funeral Svc 21. Signelure of Funeral Servica Licansee Bece P.OBox 26528 Richmond, VA. 23a. Part1. Enter the preese, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** Blut Force D /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examine Examiner physicien and the buriel-transit the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es a consequance of): 98 USB ō signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other algniffcant conditions contributing to death but not resulting in the underlying cause given in Pert f. 2 10 No 3 Probably 4 Unknown 1 Yes É 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? s certificate has t 2 No Yes 2□ No Attending Physician: director 25. Was case referred to medical Be 26. Plece of Deeth (Check only one) Hospitel: 1⊠ Yes 2□ No Other: $_{4\,\square}$ Nursing Home $_{5\,\square}$ Residence 6XX other (Specify) AT SCENE 70 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Dete of Injury (Month, Dey Year) Certification: 27. Menner of Deeth 28b. Time of 1 Neturel 5 Pending Schilet death. investigation 2 Accident octor: / 6 Could not be 3 Suicida 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) A Funeral Dh. City or Town S fomloide 5 3203 ee andry NOON 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

| Contifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Contifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and manner as stated. 29a. Certifier edical within 2 To the I 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year) OCME MARCH 1, 1999

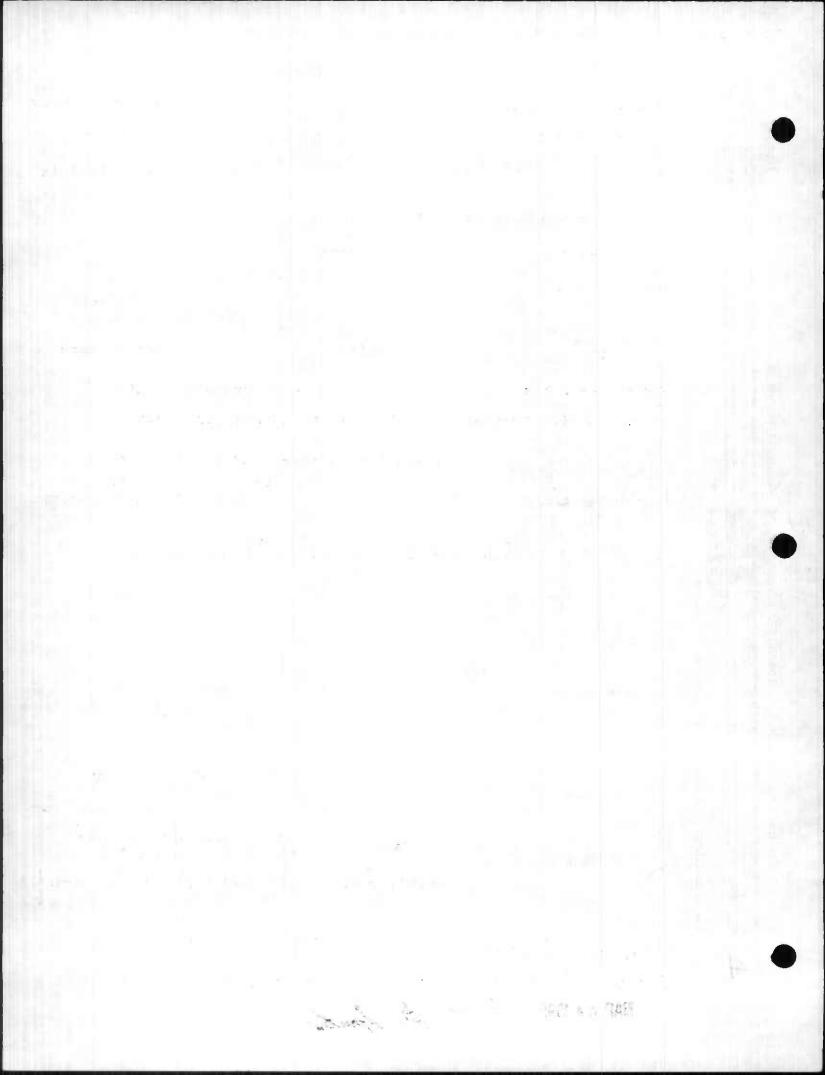
of person who completed causerol death (Item 23e) (Type, Print)

Day, Year)

MAR 0 4 1999

32. Pegisfrer's Signeture

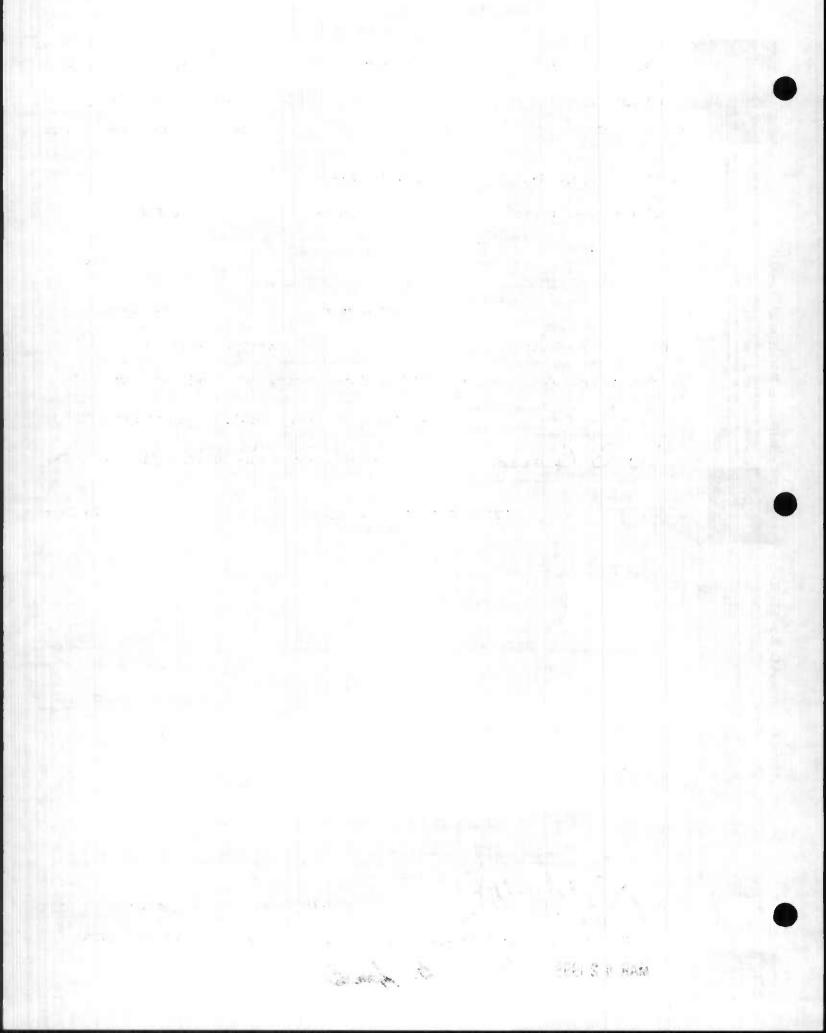
State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Source Security Number Size Siz			hwood St	reet					New Carr	collton	Pr	ince	George	e's
Signature State	Funeral		ber 6. Se	9x 7.	Age (In yrs.	last birthdey)				s. B. Dete of B				
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26. Plece of Death (Check only one) 26. Plece of Death (Check only one) 27. Very 1970 of 197	The page									1	Yes 2	No	1 □ Ye	s 2 No
27. Menner of Deeth 1 Naturel 2 Accident 3 Suicide 4 Homicide 2 Accident 3 Suicide 4 Homicide 2 Accident 5 Pending investigation 6 Could not be determined 2 Be. Place of Injury - At home, ferm, street, factory, office 2 Accident 3 Suicide 4 Homicide 2 Accident 5 Pending investigation 6 Could not be determined 2 Be. Place of Injury - At home, ferm, street, factory, office 2 Be. Place of Injury - At home, ferm, street, factory, office 2 City or Town, Stete) 2 Suicide Accident Street and Number or Rurel Route Number, City or Town, Stete) 2 City or Town, Stete) 2 City or Town, Stete) 2 Medical Examiner: On the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) end menner es steted. (Oheck only one) 2 Medical Examiner: On the best of exemination end/or Investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) 2 Medical Examiner: On the best of exemination end/or Investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) 2 Medical Examiner: On the best of exemination end/or Investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) 2 Medical Examiner: On the best of exemination end/or Investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) 2 Medical Examiner: On the best of exemination end/or Investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) 2 Medical Examiner: On the best of exemination end/or Investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) 2 Medical Examiner: On the best of exemination end/or Investigation, in my opinion, deeth occurred at the time, detered alcian: The law requires to certificate has been signe rector, page 2 should be be Completed by	25. Wes case referred								Deeth (Check only	one)				
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29a. Certifier (check only one) 29a. Certifier (check only one) 29b. Signature and little of person who completed cause of death (Item 23a) (Type, Print) D. J. Haidak, M.D., 7525 Greenway Center Drive, Greenbelt, Maryland 20770	is af of its of													
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D. J. Haidak, M.D., 7525 Greenway Center Drive, Greenbelt, Maryland 20770	1	1/	1/40	uset	N			D	17605			Ma	arch 2,	1999
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State 31. Date filed (Mortin-May, Year) 20. Registrar's Signature	10/	D. J. Hai	dak, M.I	0., 7525	Green	way Ce	enter	Dri	ve, Gree	enbelt, l	Mary1	and	20770	
	State	31. Date filed (Month)	May, Year)	20. Reg	gistrar's Sign	ature	,							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🔾 🔾 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** BARBARA ANN PROCTOR MATTHEWS 27, 1999 FEBRUARY 8:10 AM /Medicai 4a. Facility Nema (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 502 PEPPER MILL DRIVE CAPITOL HEIGHTS PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) DEC . 13, 1 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foraign **Funeral** 1 M 2 F Days MARYLAND Director 60 Yrs 1938 219-36-8587 Usual Rasidance of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 □ No Director MARYLAND PRINCE GEORGE'S CAPITOL HEIGHTS 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 502 PEPPER MILL DRIVE 20743 UNITED STATES Funeral 12. Wes Decedant Ever in U,S. Armed Forcas? 1 ☐ Yas ≥ ☑ No If Yas, Giva Yeer or Datas: 11. Maritel Status Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, etc. 1 ☐ Nevar Married 20 Merrled 1 ☐ Yas 2 ☐ No Specify: þ Specify. 3 ☐ Widowed 4 ☐ Divorced BLACK 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decadant's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Eiamentary/Secondary (0-12) Collega (1-4or 5+) HOUSEWIFE PRIVATE 10TH GRADE 17. Fethar's Nama (First, Middla, Last) 18. Mothar'a Nama (First, Middla, Maldan Surnama) MASON B. PROCTOR, SR. MARGARET ANNIE DORSEY PROCTOR 19a. Informent's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) CHARLES N. MATTHEWS / HUSBAND 502 PEPPER MILL DRIVE, CAPITOL HEIGHTS, MD. 20743 20b. Place of Disposition (Nama of cemetary, cramatory or other placa) 20e. Mathod of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) ZION BAPTIST CHURCH CEM. 3/4/99 WELCOME, MARYLAND 21. Signifure of Funaral Sarvice Licensee 22. Nama and Addrass of Facility
THORNTON FUNERAL HOME, P.A. THORNTON JOHNSON MO0583 3439 LIVINGSTON ROAD, INDIAN HEAD, MD. ZDIA C. 23a. Pert1. Entar tha disaasa, or complications that caused tha death. Do not entar tha mode of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only one cause on each line. Approximata Intervei Between Onsat and Death **Physician** /Medical Immediata Causa (Final Carcer 8 months diseasa or condition rasulting in daath) Dua to (or as a consequance of) Examiner Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or injury that initiated evants rasulting in daeth) Last Dua to (or as a consequence of): Physician/Medical Due to (or es e consequança of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No by 24b. Wara autopsy findings availabla prior to complation of causa of death? Completed 24a. Wes en autopsy performed? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical Be 28. Placa of Death (Check only ona) Other: 4 ☐ Nursing Homa 5 ☐ Rasidence 8 ☐ Other (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death

1 Natural

2 Accident 28a. Deta of Injury (Month, Day Year) Certification: 28b. Tima of 28d. Dascribe how Injury occurred 28c. fnjury at Work? 5 Panding 1 ☐ Yas 2 ☐ No Invastigation 8 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida 10 Certifying Physician: To the best of my knowledge, deeth occurred et the tima, dete end placa, and dua to the cause(s) end mannar as stated.

2 Medical Examiner: On the best of axamination and/or invastigation, in my opinion, death occurred et the time, date end place, and dua to the cause(s) and mannar stated. edical 29a. Cartifier 29b. Signature and tida of certifiar 29c. Licensa number 29d. Deta signed (Month, Day, Year) Houkala MD MARCH 1, 1999 30. Nama and address of person who completed causa of death (item 23a) (Type, Print) 1221 MERCANTILE LANE, LARGO, MARYLAND MUTOMBO KANKONDE, MD Registrar's Signeture

State Registrar

death with the Meryland

7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any Injury or other traumatic event, the Magicial Examination.

Examiner

physician and s the burial-transit

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been signed by the should be detacted

page 2 hes

uneral

certificate

To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica

Box 68760.

P.0.

Records,

Division of Vital

Baltimore, Maryland 21215-0020

HELL O RAIL

Certificate of Death

1.1.	111111111111111111111111111111111111111	101/11/1	1 14 1	
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Directo

Funeral

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Completed

State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Nama (First, Middla, Last)
Physician /Medical	Amy El:
Examiner	4e Facility Name (If not Institution, give :
	2100 BLK GOLDMIN

Amy Elizabeth Madero

2. Data of Deeth Month Day Yeer FEBRUARY 27 1999

3. Time of Death 3:00 A

1 ☐ Yes XX No

4e Facility Name (If not Institution, give street end number)

4b. City, Town, or Location of Deeth

Min

4c. County of Death

Funeral

2100 BLK GOLDMINE RD 5. Social Security Number 214-88-6946 1□M 2\ F 24

If Undar 1 Yeer If Under 24 Hrs. 7. Age (In yrs. last birthday) Days Hours

20862

MONTGOMERY Birthplaca (Stata or Foraign Country) 8. Date of Birth (Month, Day, Year)

Director

with the Meryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Merylen Department of Health and Mentel Hyglena. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Meoical Exempted months and page.

Physician /Medical

Examiner

physician end the buriel-transit

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signed by t

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certificate has b

Director: A

24 hours after Funeral Directles

To the I within 2 To the f

The law requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records,

or Attending Physician:

Examiner

Physician/Medicai

ð

Completed

Be

2

Certification:

10a, Stata 10b. County Maryland Montgomery 10c. City, Town or Location Brinklow

3/26/74 Washington, D.C. 10d. Insida City Limits

10e. Street end Number

Usual Residence of Dacedant

10f Zin Coda

Yrs.

10g. Citizen of What Country?

USA

20000 New Hampshire Ave.

1XX Nevar Married 2 Married

12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Datas:

13. Was Decadant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, etc.) 1 ☐ Yas 2 ▼ No Specify:

14. Race - Amarican Indian, Black, Whita, atc. Specify: White

3 ☐ Widowad 4 ☐ Divorced

Elemantery/Secondary (0-12)

15. Decedent's Education (Specify only highast grada completed) Collega (1-4or 5+)

16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Catering

16b Kind of Rusiness/Industry Food Service

17. Fether's Nama (First, Middle, Last)

William F. Madero, Sr.

18. Mothar's Nama (First, Middla, Maidan Sumema) Elizabeth Joan Case

19a. Informant's Name/Ralationship (Type, Print)

Same as item 10

19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code)

Wm. F. Madero, Sr./Father

20b. Place of Disposition (Nama of cematary, crametory or other place)

20c. Location - City or Town, Stata

20a. Mathod of Disposition

1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from Stata 4 ☐ Donation 5 ☐ Othar (Specify)

Gate of Heaven Cemetery 3/2/99

Wheaton, MD.

21. Signature of Juneral Service Licensee

22. Name end Addrass of Facility George P. Kalas Funeral Home, P.A.

ales

6160 Oxon Hill Rd. Oxon Hill, MD. 20745 hat causad the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest,

Approximata Intarval Batween Onsat and Death

Immedieta Causa (Final disaasa or condition resulting in death)

Neck Injuries

Due to (or as a consequance of):

Due to (or es e consequence of):

Sequentially list conditions, if any, laading to Immadiata cause. Entar Undartying Causa (Disaasa or injury that initiated evants rasulting in daath) Lest

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 25 No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en eutopsy performad?

24b. Wara autopsy findings availabla prior to complation of ceuse of daelh?

1 Yas 2 □ No

1 PYas 2□ No

25. Wes cesa refarrad to medicel examinar? 1 XYas 2 No 27. Mannar of Death

5 Panding invastigation

6 Could not be datarmined

Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Tima of Injury 28a. Data of Injury (Month, Day Year) 2-27-99

Other: 4 Nursing Home 5 Rasidence 6 NOther (Specify) SCENE 28c. Injury at Work? 0230M

1 Yes 2 No

26. Piece of Deeth (Check only one)

28d. Dascribe how injury occurred Occupant auro roll over

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) Roadwar

28f. Location (Street and Number or Rural Route Number, City or Town, Steta) East 2104 Gold Mine Rd

29a. Cartifiar (Check only one)

1 Natural

2 Accident

3 Suicida

4 Homicide

Certifying Physician: To the bast of my knowledge seath occurred et the time, data end place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signetura end title of certifier

29c. Licanse number O.C.M.E

29d. Date signed (Month, Dey, Year) FEBRUARY 27,1999

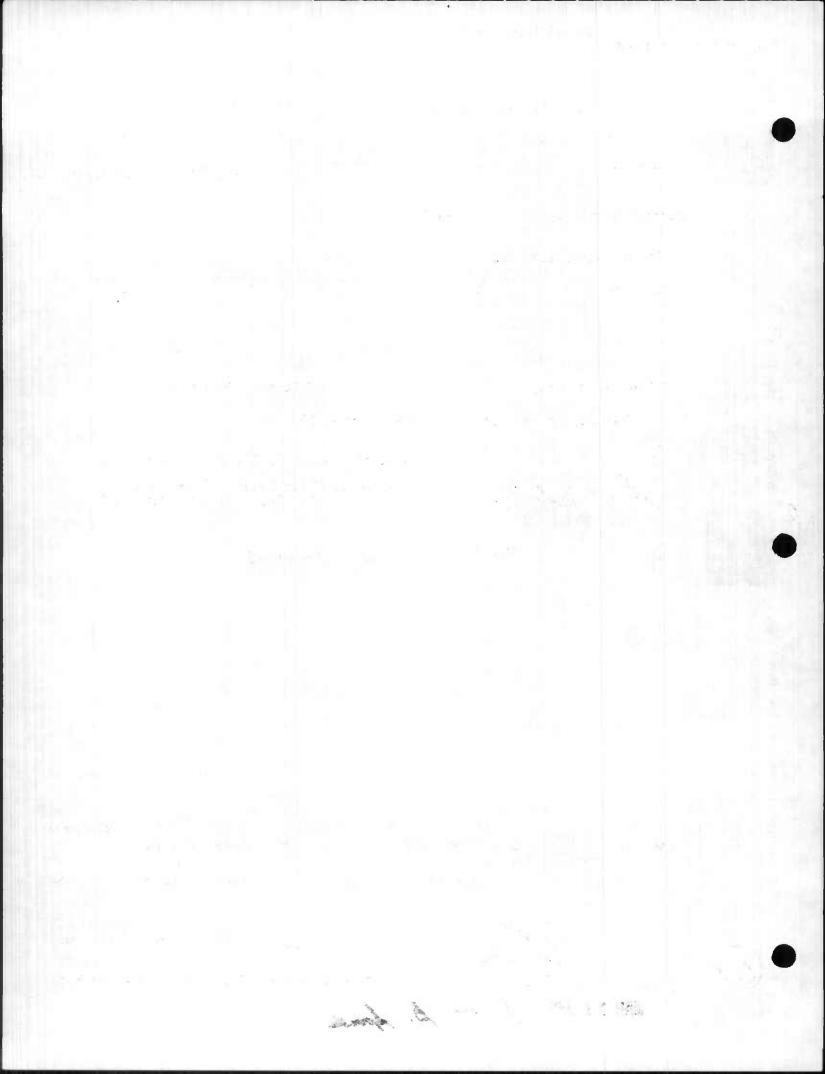
30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print) Jav. a

Fowler

111 Penn Street, Baltimore, Maryland 21201

Registrar



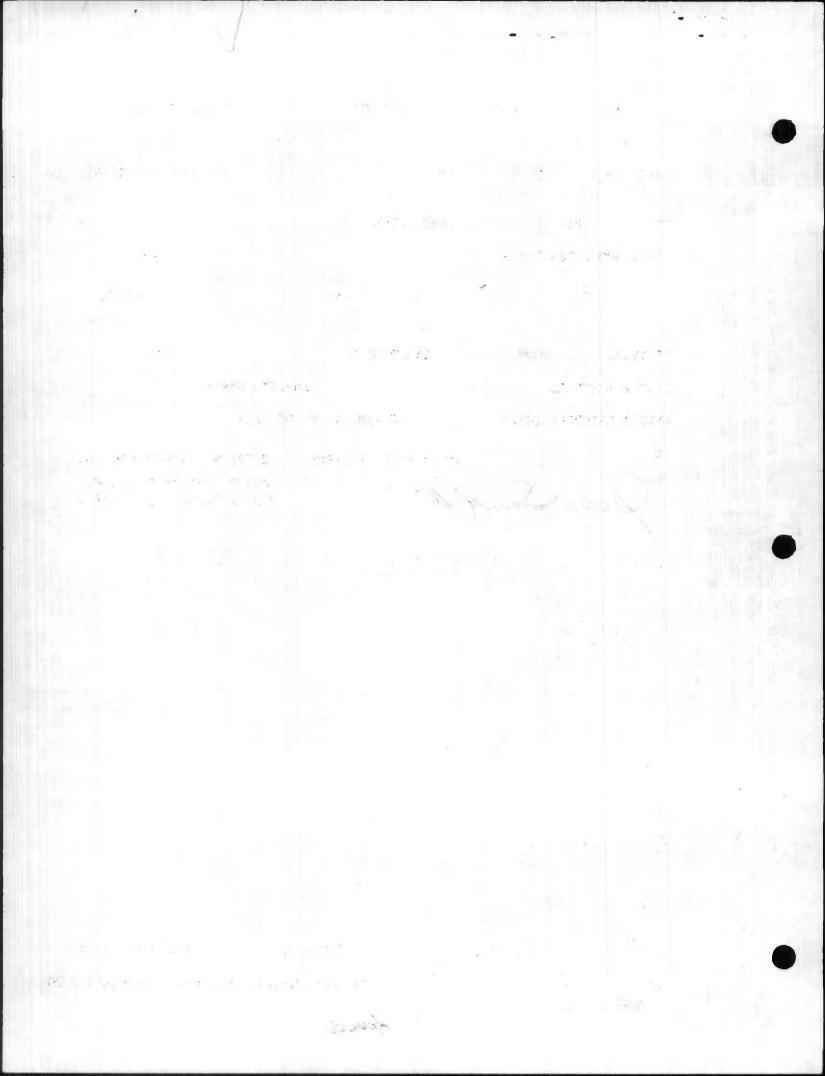


99-1061-033

HARRY MITCHELL	Decedent's Neme (First, Middle, La	State of Mar		artment of rtificate o			Reg. No.	088	26
Physician /Medical	HARRY 4e Fecility Neme (If not institution, give	TRENT	MIT	CHELL	4b. City, Town, or	Month FEBRUA	Dey RY 23,19	Year 999 3:4	OP.M.
Examiner Funeral Director	1161 SOUTHVIEW DF 5. Social Security Number 6. S	RIVE	X 7. Age (In yrs. last birthday) If U			S. 8. Date of Bit (Month, De 12/27	PRINC	SINCE GEORGES 9. Birthplace (State or Fore Country) ATLANTA, GA.	
pu >	Usual Residence of Decedent 10a. State 10b. County		0c. City, Town or Lo	ecation				10d Inci	de City Limits
vith the Merylen or 28a-f show be notified at Director	MD PG 10e. Street and Number		OXON HI		8		10g. Citizen of	Whet Country?	Yes 2 No
ter death v	1441 SOUTHVIEW 11. Maritel Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	DRIVE 12. Was Decedent Even Armed Forces? 1 Yes No If Yes, Give Yeer or Dates:		Was Decedent of Yes, specify C	of Hispanic Origin? (suben, Mexicen, Puer No Specify:	Specify Yes or No rto Rican, etc.)	Bla	A ce - Americen Indie ck, White, etc. BLACK	on,
d within giene.		College (1-4or 5+)	16a. Decee (Give life.		ne during most of wo tired)		NONE	Business/Industry	
d 2 should be filed within the and Mantel Hygiene. The marked other than traumatic event, trailing To Be Comp	17. Father's Name (First, Middle, Last JESSIE MITCHELL		1		LUBERTA	A MARIAN			
CENL	19a, Informant's Name/Relationship (SHEILA MITCHELL				NE, DC 20		oer, City or Town	n, State, Zip Code)	
一五百有	20a. Method of Disposition 1 Burial 2 Cremetion 3 4 Donation 5 Other (Special		20b. Place of Disponentery, cree	natory or other	place)	Date /27/99		- City or Town, Ste	te
permit. Pages Depertment of Important: If it any injury or once.	21. Signature of Furniral Service Lice	Sou is	W 25	2. Name end Ad	dress of Facility JOI 303	HN T. RH	INES CO	., INC.	
Physician /Medical Examiner	23a. Part 2 Enter the disease, or companies, or hear takers. List only Immediate Cause (Finel disease or condition resulting in death)	a. Phe	umonia		dying, such es cardie	ac or respiratory a	arrest,	Interva	klmate il Between and Death
at the death certificate be executed by the attending physician and eteched for use as the buriel-transit Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in deeth) Last	C	ue to (or as a consequent						
at the d by the eteched	Part II. Other significant conditions of	contributing to death but r	not resulting in the u	nderlying cause	given in Pert I.		Yes 2 No	ontribute to the ca	use of death
aw request been 2 shou						24a. Was	s an autopsy ormed?	24b. Were euto available completio of death?	
iclan: The certificate hector, page	25. Was case referred to medical				26. Place of De	eeth (Check only	≪es 2□No one)	Yes	2 No
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	exeminer? 10 Yes 2 No 27. Manner of Death 10 Naturel 5 Pending 2 Accident investigatio	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Y	28b. Time o	f 28c. I	Other: 4 Nursing njury at Work? 1 Yes 2 No	Home 5□ Res 28d. Describe	how injury occu	ner (Specify)	ative':
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State Registrar

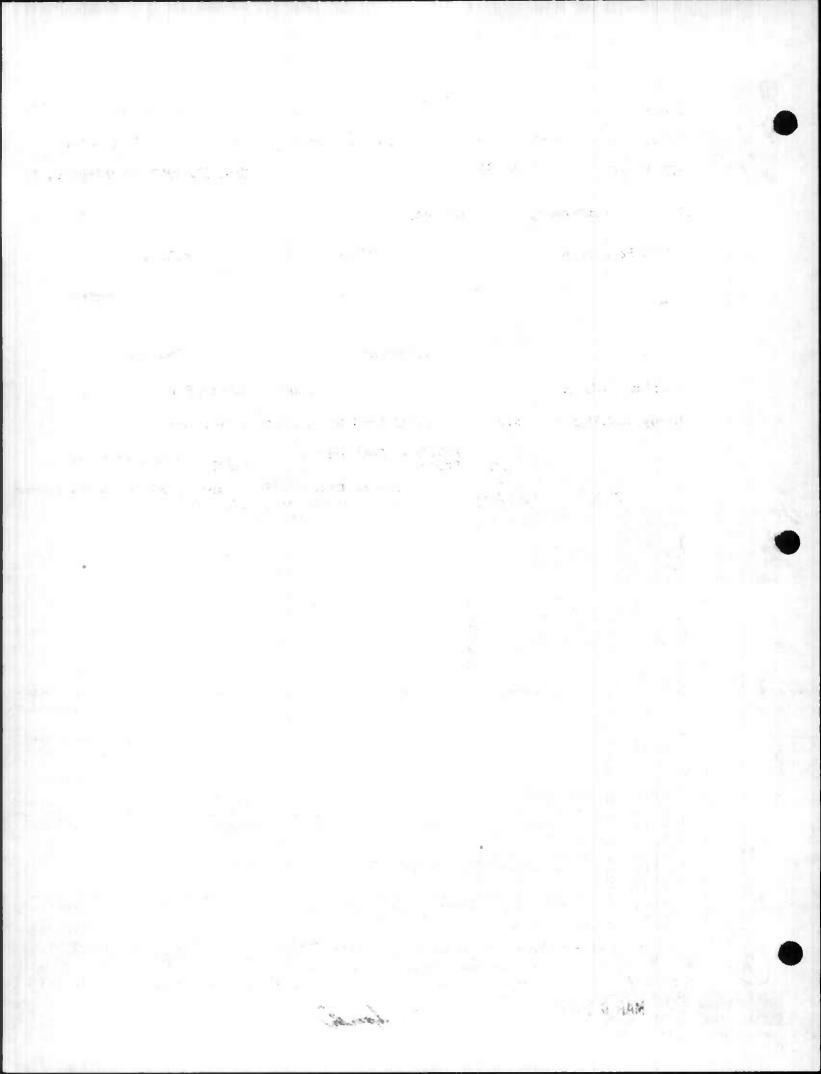
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 0882

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ician	1. Decedent's Name (First, Middle, L	ast)					2. Date of De Month	Day	Year	Time of Death
1		ASSEY					FEBRUA	RY 24, 1	999 1	:43 P.M.
ner	4e Fecility Neme (If not institution, g		r)			4b. City, Town, or				
	HOLY CROSS HOSP 5. Social Security Number 6.		Ama (In uma	last birthday)	If Under 1 Year	SILVER S			GOMERY	
	241-36-2727 Usual Residence of Decedent	1∑M 2□F	73	Yrs.	Months Days		AUG. 3	ay, Year)		(State or Foreign CAROLINA
	10a. State 10b. County		10c. Cit	ty, Town or Loc	ation		F-E		10d. l	nside City Limits
Director			WAS	SHINGTO	N, D.C.				1	¥ Yes 2 No
5	10e. Street and Number				10f. Zip Code			10g. Citizen of V	What Country?	
	610 IRVING STRE	ET, N.W.			20004			UNITED	STATES	
	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Force 1 Yes 2. If Yes, Give Year or Dates	s? No	lf lf	as Decedent of Yes, specify Cul ☐ Yes 2 ☐ No	Hispanic Origin? (Span, Mexican, Puerlos Specify:	pecify Yes or No o Rican, etc.)		e - American Ir ck, White, etc. : BLAC	
	15. Decedent's (Specify only highest g	Education		16e. Decede	ent's Usual Occu	pation during most of wo	rkina	16b. Kind of B	usiness/Industr	у
Completed	Elementery/Secondery (0-12)	College (1-4o	r 5+)	life. D	O NOT use retin	ed)	All g			
	12			MACH	INIST	40. Mark ada Miri	n a (Final Adiable	FACTORY	221	
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	TYRONE THOMPSON,					., N.W.,				
ŀ	20a. Method of Disposition	METHEM	20b. F	Place of Dispos			Date	20c. Location		-
	1 XBurial 2 ☐ Cremation 3 4 ☐ Donetion 5 ☐ Other (Spec		0		COLN CEM		3/2/99	BRENTWO	OD. MAI	RYLAND
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	Desa S.	Duris	OIL			OLN FUNER ENSBURG R		TIME TO OD	MD 2071	2
er	Immediate Ceuse (Finel disease or condition resulting in death)		Due to (d	DIAC DE	ence of):				Ons	set and Death
Examine	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury	b. DIABE		ELLITUS or as e consequ					1	
edicai	Cause (Disease or injury that initiated events resulting in death) Lest	C	Due to (c	or es e consequ	ence of):	- 425			1	
		l d								
Completed by Physician's	Pert II. Other significant conditions	contributing to death	but not res	sulting in the un	derlying ceuse g	iven in Pert I.	23b. Did	tobacco uss co	ntribute to the	cause of death?
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								an autopsy ormed?	availab	utopsy findings le prior to tion of cause h?
1							10	Yes 2 X No	1 □ Ye	s 2 X No
	25. Was case referred to medical examiner?	Hospital:				thor:	ath (Check only			
2	1 Yes 2 No 27. Manner of Death	1 X Inpa		ER/Outpatient	3LI DOA	4 LI Nursing i		how injury occur		
Certification:	1 Natural 5 Pending investigati 3 Suicide 6 Could not determine	on (Month, L	Dey Year)	injury ome, farm, stre	M 1E	Yes 2□No	28f. Location	(Street and Numt		ute Number,
edical Cert	29a. Certifier 12 Certifying F	hysician: To the besiminer: On the basis		owledge, death			, end due to the			
Medi	one)	and manner		and and of the			and of the time,			
-	29b. Signature and title of certifier Suzy	ando		1) 01	4876		29d. Dete signe		r ear)
/	30. Name and address of person who SURESH C. GUPTA					CHITE 203	POCKA	TITE MI	20852	

Maria .

1/8 0 0 9**3**

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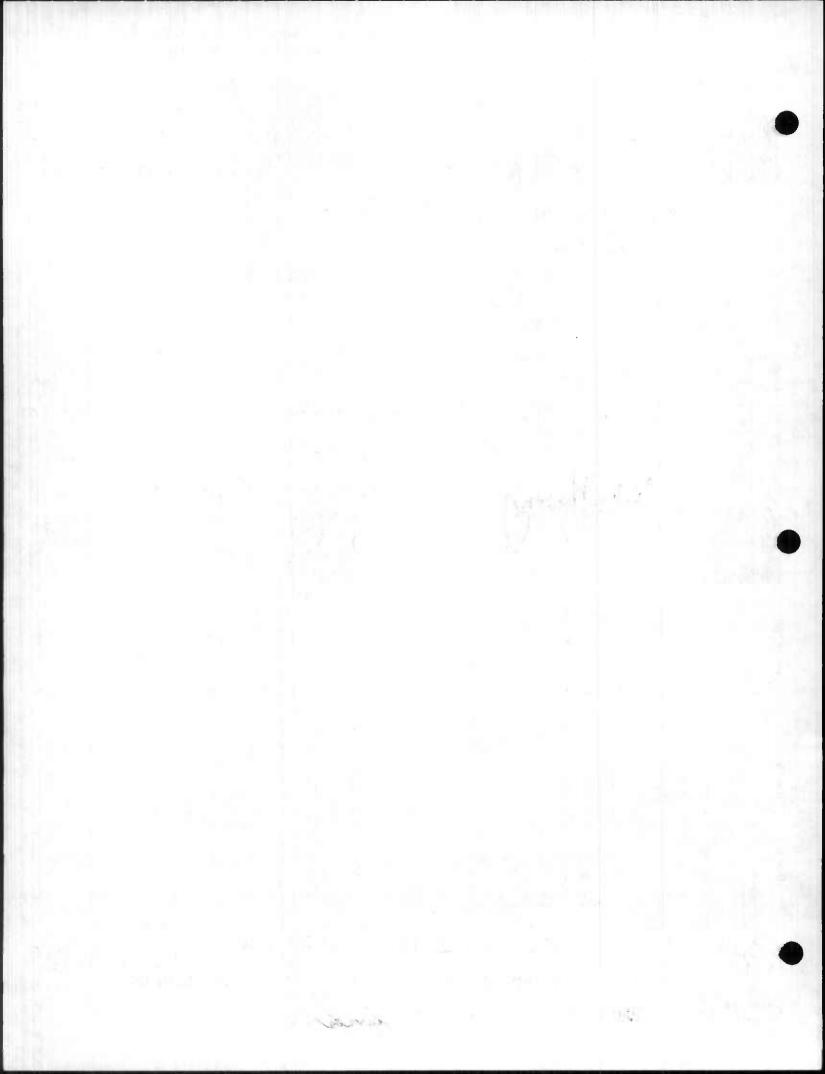
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) **Physician** 1999 February 5:45AM MAGGIE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner #203 Prince George's 4111 Southern Ave., Capitol Heights | Hundar 1 Yaar | Hundar 24 Hrs. | 8 Data of Birth (Month, Day, Year) | Min. | May 24, 19 Birthplaca (Stata or Foraign Country) 7. Aga (In yrs. last birthday) **Funeral** 1 M 2 X Yrs. 1907 91 North Carolina Director Usual Residence of Decedant the Menylend 10a. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Maryland Prince George's Capitol Heights Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 4111 Southern Ave., #203 20743 United States Funeral filed within 72 hours after death 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐XNo Specify: Negro à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Spacify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b Kind of Business/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) Hygiene. Clerk Government permit. Pages 1 and 2 should be file Department of Heath and Mentel Hy Important: If item 27 is marked othe any Injury or other traumatic event bace. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) John Howie Ola Spears 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Straet end Number or Rural Routa Number, City or Town, Stete, Zip Code) 4111 Southern Ave., #203; Capitol Hgts., MD 20743 Joyce Matthews - Daughter 20b. Placa of Disposition (Nama of camatery, crematory or other placa) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 □ Donation 5 □ Other (Specify) 3/6/99 Lincoln Memorial Ce. Suitland, MD 21. Signatura of Funaral Sarvice Licenses 22. Nama and Addrass of Facility Stewart Funeral Home ewar 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, should be heart failure. List only one cause on each line. N.E. Wash., D.C. Approximata Intarval Batween Onset and Death **Physician** /Medical immediata Causa (Final disaasa or condition resulting in death) Complication of Examiner Dua to (or as a consequence of) Examiner pertension attending physician end for use es the buriel-trans Sequentially list conditions, if any, laading to immadieta cause. Enter Underlying Cause (Disaasa or Injury that initiated evants rasulting in daath) Last requires that the death certificate be exec Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical signed by the a 23b. Did tobacco use contributs to the causs of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 3 Probably 4 Unknown 1 Yes 2 No Aq 24b. Wera autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of causa of death? lase 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical examiner? Be 26. Placa of Daath (Check only ona) To Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatlent 3 ☐ DOA Othar: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 1 XYas 2 □ No After this 28e. Data of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? or Attending 1 ⊠Neturel 2 ☐ Accident 5 Pending invastigation 1 TYas 2 No death. after death 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 I Homicida 24 hours Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and piece, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, data end piece, end due to the cause(s) end menner stated. 29a. Certifie edical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of cartifiar 29c. Licansa number 30111 March 1, 1999 mee MIN 30. Name and addrags of parson who complated causa of death (Itam 23a) (Type, Print) Beltsville MA 20705-1757 Jones W 32. Registrar's Signatura 31. Data filad Month, Day, Year) MAR 0 2 1999 Registrar

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		Decedent's Name (Fin	ret Middle I as	t)			ertificate of		Mental Hy	Reg. No.		000) U
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uneral irector		5. Sociel Security Number 517-01-4	224	x ⊐M 2]X)F		yrs. lest birthda 35 Yrs.	y) If Under 1 Yea Months Days			24,191	9. Birthp Coun — M	lece (Stete ONTAI	or Foreign
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2		9b. Signature end title of	Sch	mpleted cause	of death	M, V)	29c. Licen:	3661	8	Pelrua	(Month, E	7, 19	799
	3	DR . C	HRIST(SCHE		01- VEI	RS DR.,	ROCKV	ILLE,MI).		



Baltimore. Maryland 21215-0020

					Cer	tificate	of I	Death			Reg. No.	0	0001
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Physici		Samuel Richard M	OORE						r	Month C	n G	1990	1 0650
/Medic Examir		4e Facility Neme (If not Institution, gir	re street and numi	ber)			4	b. City, Tow	m, or Loca	ation of Deet	th 4c. Co	unty of Deet	
a.r.a.iiii		Washington Count	v Hospit	a1				Hag	ersto	own	Wa	shing	ton
Funeral			-	. Age (In yrs. I	ast birthday)	If Under 1		If Under 2		B. Dete of Bi	rth		hpleca (Stete or Foreiguntry)
Director	Н	212-24-5683	1 M 2□F	70	Yrs.	Months	Days	Hours			9 1929		land
2		Usual Residence of Decedent											
how		10a. State 10b. County		10c. City	, Town or Loc	cation							10d. Inside City Limits
W Per	cto	Maryland Washin	gton		Smiths	sburg							1 ☐ Yes 2 🎇 No
with the Marylenx a or 28a-f show be notified at	Director	10a, Street and Number				10f. Zip (Code				10g. Citizen	of What Co	untry?
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permit. Pages Department of I Important: If its any injury or of		21. Signature of Funeral Service Lice	nsee		22.	Name end	Addres	ss of Fecility	Minr	nich F	uneral	Home	
827.9		Fred La	Letel								rstown		yland
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Division of Vital Records, P.O. Box 68760. To the Hospita within 24 hours To the Funeral complately filled

Samuei Richard Moore

State Registrar

Medical

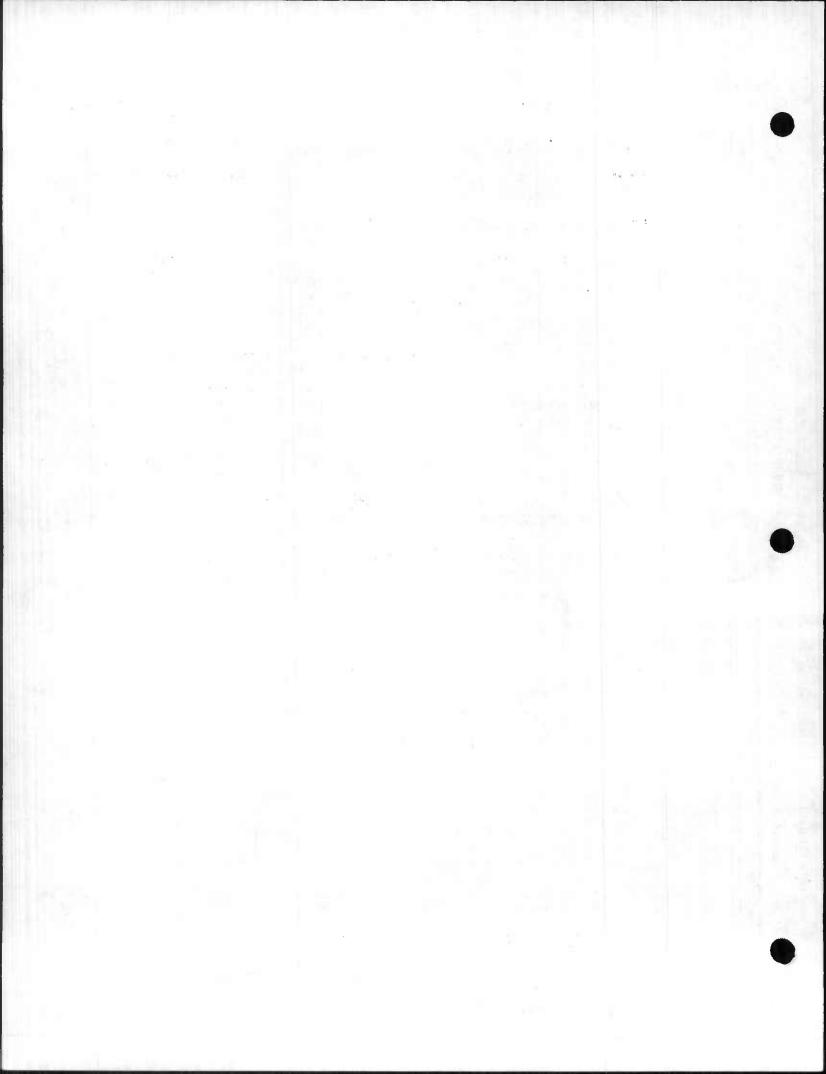
29a. Certifier (Check only one)

31. Dete tiled (Month, Dey, Year) MAR 1

death (ttem 23a) (Type, Print)

1 Cortifying Phyetclan: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Name (First, Middla, Last) 2. Date of Death **Physician** Lula Edna McCarty 03 08 1999 14:00 /Medical 4e Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 29 N Mill Street Clear Spring Washington If Under 1 Yaar | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1□ M 2√2 F MB' 217 32 6506 93 10-06-1905 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic avant, the Medical Example mental to notified at 1900s. 10a. Stata 10b. County 10d. Inside City Limits MD Washington Clear Spring XXYas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29 N Mill Street 21722 U.S..A Funeral 14. Race - Amarican Indian, Black, White, atc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yas, Giva Year or Dates: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 Yas 2 No Specify: þ 3 ☑Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) residence Homemaker 8th grade 17. Fathar's Name (First, Middle, Last) 18. Mothar's Neme (First, Middle, Meiden Sumema) Jerimiah Wiley Susan Unknown 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Helen Somers 11905 Cheryl Dr. Hagerstown, MD 21742 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cemetary, crematory or other plece) 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from Stata Rose Hill Cem. March 12, 1999 Clear Spring, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Service Licensee 22. Nama and Addrass of Facility Donald Edwin Thompson Funeral Home, Inc. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

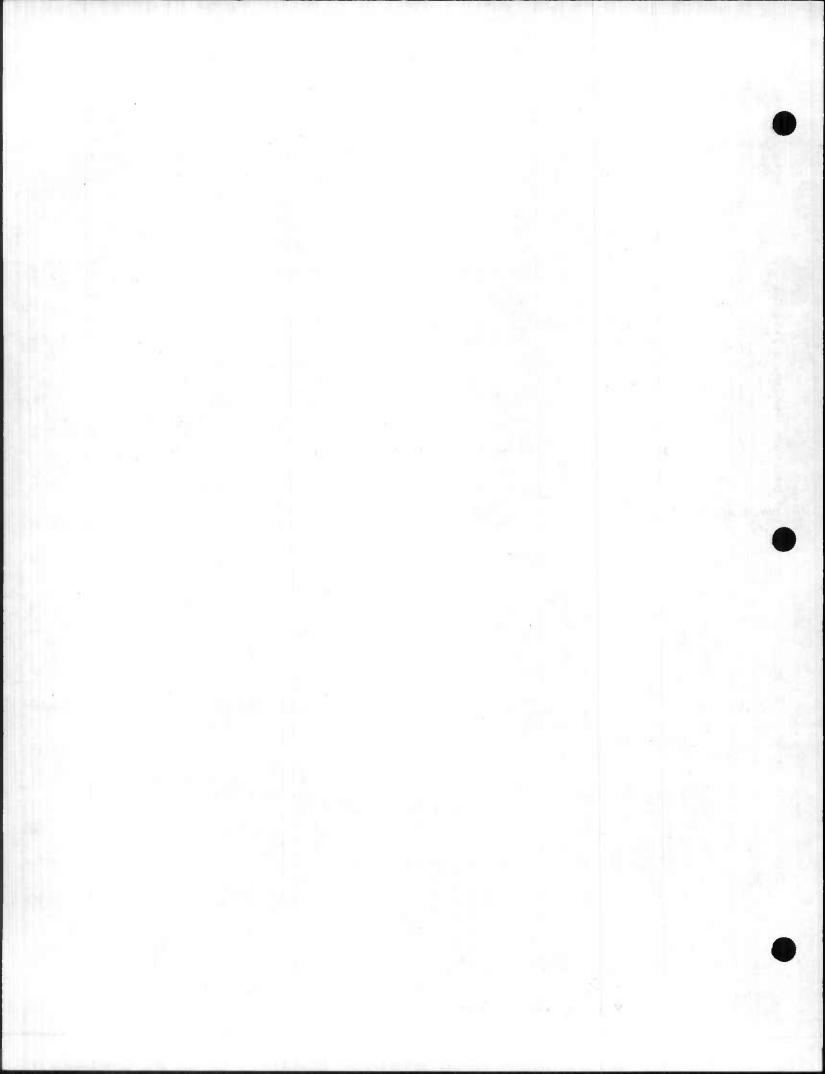
Approximately a such as cardiac or respiratory arrest,

Approximately a such as cardiac or respiratory arrest,

Approximately a such as cardiac or respiratory arrest,

Approximately a such as cardiac or respiratory arrest, Approximata Intarval Between Onset and Deeth **Physician** Immediata Causa (Final disease or condition resulting in death) /Medical Cardiopulmonary Arrest instant Examiner Due to (or as a consequence of): Examiner Arteriosclerotic Heart Disease hysicien end the burial-transit many years The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Box 68760. Hypertensive Cardiovascular Disease Physician/Medical many years Due to (or as a consequence of): 88 use P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Dementia of Alzheimer's type of Vital Records, by 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? Completed Undernutrition completion of causa of death? page 2 this certificate 1 Yas 2 No 1 ☐ Yas 2 ☐ No or Attanding Physician: 25. Was casa referred to medical examiner? Be 26. Placa of Deeth (Check only ona) Hospital: 1 Inpetient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) Certification: To 1 Yas 2 No funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Aftar Division 1 Natural 5 Pending invastigation 1 Tas 2 No 24 hours after death.

Funeral Director: A 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) à 4 Homicide filled in Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, dete end place, end due to the cause(s) and menner as stated. completely 2 Medical Examiner: On the basis of axaminetion and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifier 29c. Licensa number ale 4 D07857 03-09-1999 30. Nama and address of person who completed pulsa of death (Item 23a) (Type, Print) 1190 Mt. Aetna Road, Hagerstown, Maryland 21740 Edson B. Moody, M.D. 31. Data filed (Month, Pay, Year) MAR 1 0 1999 32. Registrar's Signeture State Registrar



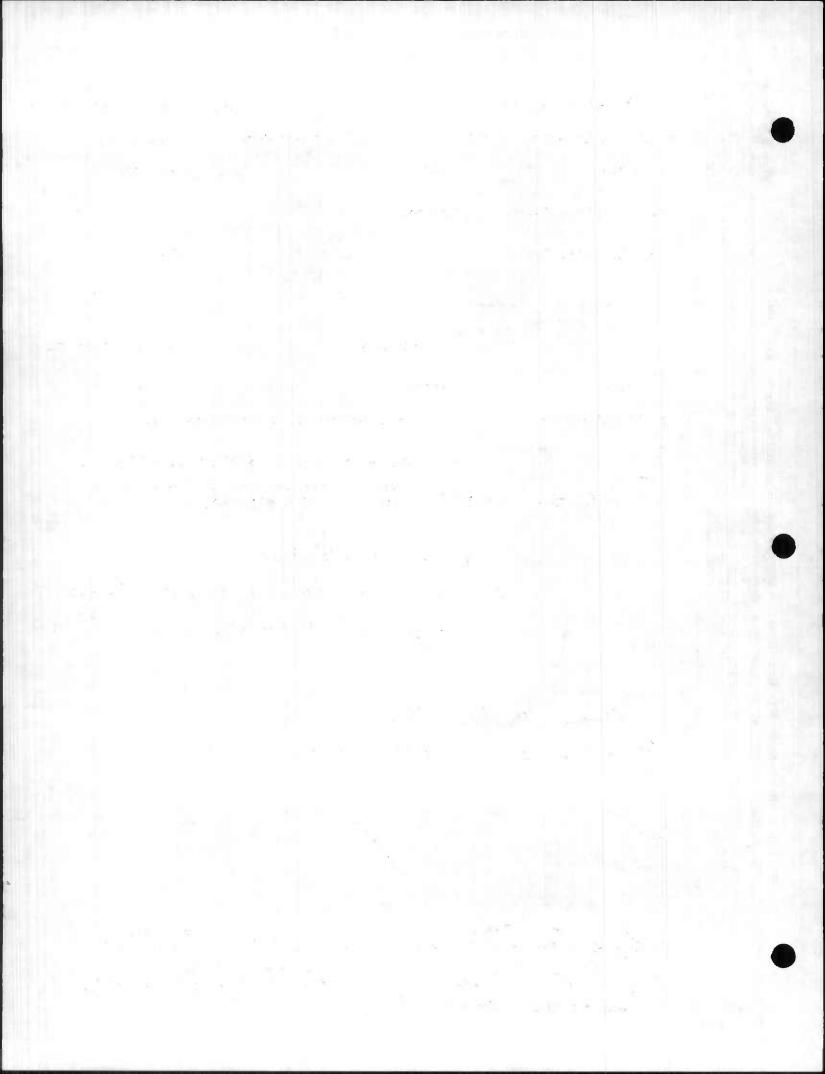
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Deeth **Physician** Nida Belle McDonald 7:10 AM Mixach /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. Feb. 12, 1919 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** 1□M 2₽F 232-26-3145 80 Yrs. Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Depertment of Haulth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a.d.m. any injury or other traumatic event, the Maryland DOCE. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Prince Georges Greenbelt 1 X Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Q Research Road 20770 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien. 11. Maritel Status 1 Never Married 2 Merried 1 ☐ Yes 2 ☒ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Secretary Federal Government 18. Mother's Neme (First, Middle, Malden Sumeme) 17. Fether's Neme (First, Middle, Last) Peter Arbogast Stella Turner 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 4904 Deleware St. College Park, Md. 20740 Margaret S. Atkinson 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition N☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 3/10/99 Maysville, Wv. Berg Family Cemetery 22. Neme end Address of Fecility
Burner Trade Services 1037 Dual Place 21. Signature of Funerel Service Licenses nal Burner. Y M35 E Hagerstown, Md. 21740-5914 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximata Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel diseese or condition resulting in deeth) /Medical **Examiner** abstract NZ Lung Discos 20 yrs Physician/Medical Examiner Due to (or es e consequence of): physician end s the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that Initieted events resulting in deeth) Lest Due to (or and consequence of): Division of Vital Records, P.O. Box 68760 attending p for use es 50 ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by ti 1 ☐ Yes 2 ☐ Do 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? Completed Hypertansion Jas 2 1710 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Wes cese referred to medical exeminer? Be 26. Piece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 npatient 2 ER/Outpetient 3 DOA this After this funeral 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 1 Maturel 5 Pending efter deeth.

Director: After d in by the fur 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) a 24 hours efter der Tuneral Director Detely filled in by the 3 Suicide 28e. Plece of Injury - At home, ferm, preet, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier edicai To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end plece, end due to the ceuse(s) end menner steted. (Check only one) 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signeture and title of certifies room P10298 120 Carroll 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Sandstrom

State Registrar 31. Dete filed (Month, Day, Year)

MAR 0 8 1999

32. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month JAMES NAYLOR FEB. 27 1999 2140 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Death ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. (Month, Day, Year)
MARCH 9 1 Birthplace (State or Foreign Country)
 MARYLAND 5. Social Security Number 7. Age (In yrs. last birthday) 1 M 2□ F 218-28-0355 1933 65 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND ANNE ARUNDEL ANNAPOLIS 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21403 US 1001 PRESIDENT STREET 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No If Yas, Giva 1 Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 0 LABORER SELF EMPLOYED 2nd 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) BENJAMIN NAYLOR ELIZABETH BUTLER 19e Informent's Neme/Relationship (Type Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1001 PRESIDENT ST. ANNAPOLIS, MD. 21403 ROSIE SELLMAN (SISTER) 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, Stete cemetery, cremetory or other place) 1 Burial 2 Cramation 3 Removel from Stete 4 Donetion 5 Other (Specify) ANNAPOLIS MEM. GARDENS 3/5/99 ANNAPOLIS, MD. 21. Signeture of Funerel Service Licensee 22. Name and Address of Fecifity WM. REESE & SONS MORTUARY, P.A. J. Leese arre 821 WEST ST. ANNAPOLIS, MD. 21401 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ona cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Finel diseese or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Dua to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 2 NO 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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Baltimore, Maryland 21215-0020

Director

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 1e marked other eny Injury or other treumatic event page.

Examiner physician and s the burial-transit P.O. Box 68760. Physician/Medical signed by d be detacl Records, þ Completed Division of Vital Hospital or Attending Physician: Be Medical Certification: To death. hours after death uneral Director: To the Hospital or within 24 hours aft To the Funeral Di completely filled in

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pad II. 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 2 ER/Outpalient 3 DOA 1 Yes 2No 27. Menner of Death 28a. Date of Injury (Month, Dev Year) 28h Time of 28c. Injury et Work? 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es stated.

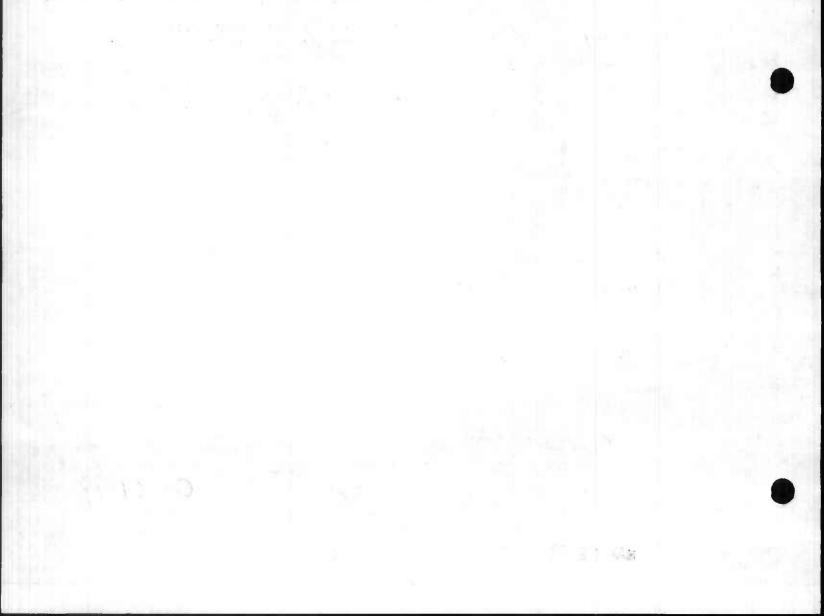
| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier

29b. Signatura and thin of certifier 29d. Date sighed (Month, Day, Year)

nted cause of de

31. Dete filed (Month, Dey, Year)
WAR 0 2 1999 gistrer's Signeture

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Thomas Wilfred Owens March 6, 1999 9:15 PM 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death Solomons Nursing Center Solomons Calvert If Under 24 Hrs. Hours Min. If Under 1 Year 5. Sociel Security Number Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 M 2 F Months Days 80 Yrs. 218-09-0934 April 3, 1918 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 Yes 2 No Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18071 Three Notch Road 20653 United States 14. Race - American Indien, 12. Wes Decedenf Ever in U,S. Armed Forces? 1 ☐ Yes 2 ■ No Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Merried 2 Married If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White 18a. Decedent's Usual Occupetion (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 Electrician Electrical 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) Robert Warren Owens Ethel Marie Dameron 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) John W. Owens, Son P.O. Box 757, St. Inigoes, Maryland 20684 20b. Pleca of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Michael's Cemetery 3/10/99 Ridge, Maryland 21. Signature of Jameral Servi 22 Name end Address of Facility
Brinsfield Funeral Home, P.A. Brins N! 22955 Hollywood Road, Leonardtown, MD 20650 Weld, M00052 Jr. 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death ew Immediate Ceuse (Final disease or condition resulting in death) Due to (or es e consequenca of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequenca of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death 2 3 Probably 4 Whknown 1 Tyes 2 No A RTERY DISTABLE 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? DRONAR ule. Sacra 1)ecu 1 Yes 2 No 1 Yes 2 No 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Yes 2 🗆 No

certificate be executed physician and the buriel-trans P.O. Box 68760. 88 esn ò signed by the e Records, page 2 has funeral director, this

Physician

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7 is marked other than "naturel", or items 23a or 28a-f show treumstic event, the Medical Examiner must be notified at

Peges 1 and 2 should be filed within 72 hours effernent of Health and Mental Hygiena.
Int: If item 27 is marked other than "naturel", or the lary or other treumatic event, it what call Examinate.

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2 25. Wes case referred to medical 1 Yes 27. Manner of Death 1 Natural 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, end due to the cause(s) and manner as stated. 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) and menner steted. (Check only one)

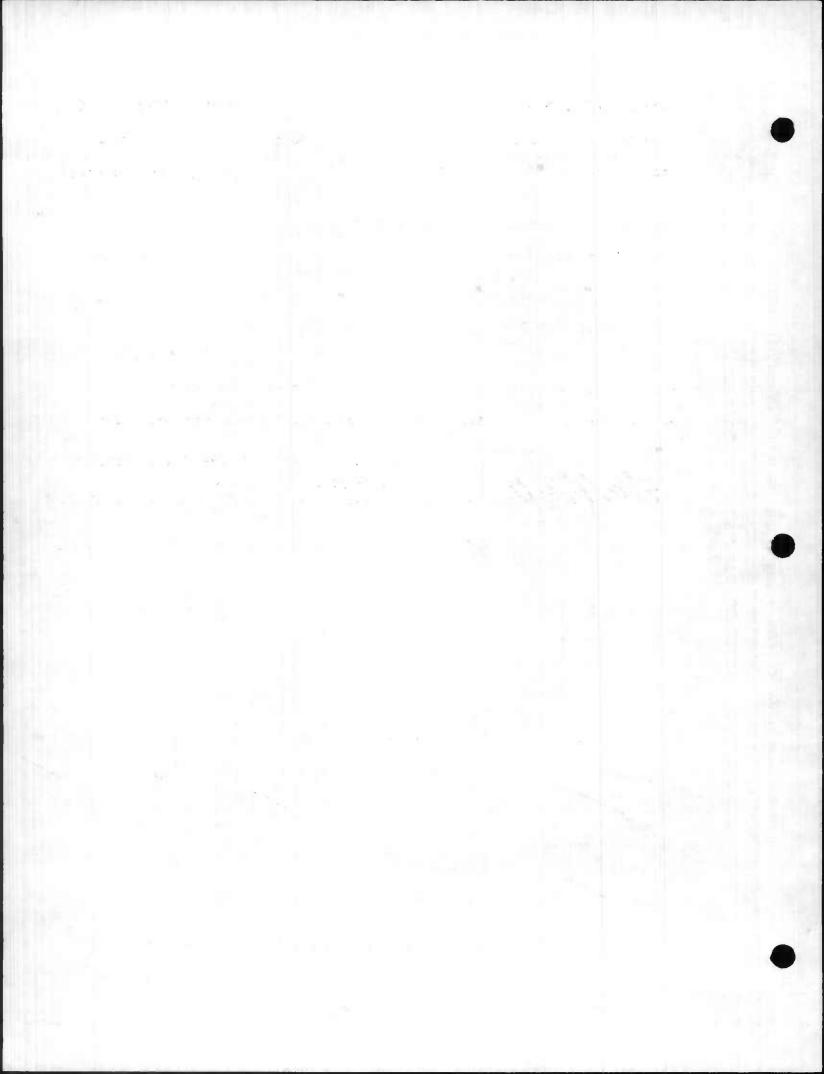
29c. License number 29d. Date signed (Month, Day, Year) Allender

30. Name and address of person who completed cause of death (tem 23a) (Type Print)
Sut 303 10 HOSPRD. Print) HOSP Sul 303 110

31. Date filed (Month, Day, Year) MAR 1 0 1999 State Registrar

29b. Signature and title of cartifier

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

				Certificat	e of	Death		F	Reg. No.	Not had		
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Physician /Medical	ESTHER CECELI	A MAGI	LL	PUMI	PHRE					, 1999	0650	
Examiner	4e Fecility Neme (If not institution, gi CALVERT MEMORIA					PRINC	E FRI	cation of Death EDERICK	,			
uneral irector		Sex 7. Ag 1 □ M 2 🖾 F	a (In yrs. lest bird 81	lest birthday If Under 1 Year If Under 24 H Months Deys Hours Mi			24 Hrs. Min.	8. Date of Birth (Month, Day 02/13/1	Year) 1918	Countr	ce (Stete or Foreign NIER MD	
*	Usuel Rasidance of Decedent 10a. Stete 10b. County		10c. City, Town	n or Location	_			104			1. Inside City Limits	
sa-f ahov riffied at	MD CALVERT		HUNTINGTOWN					10			1 ☐ Yes XX No	
r items 23s or 28s-fs niver must be notified Funeral Director	10e. Street and Number 6611 JUPITER DR	VE		10f. Zip)639				10g. Citizen of V USA	What Country	y?	
by by	11. Meritel Stetus 1 Never Merried 2 Married 3XXWidowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If If Yes, Giva Year or Datas:		13. Was Dece If Yas, spe 1 Yes	cify Cub	an, Mexicar	gin? (Spe n, Puarto I	ecify Yas or No- Rican, etc.)		e - Americar ck, Whita, et v: Wh		
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om 27 is other trau	John E. Pumphrey			6611 Juj								
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Important: If it any injury or once.	tXXBurial 2 ☐ Crametion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Spec			cemetery, cremetory or other plece)					Suitla	nd MD		
any Injury or pnce.	21. Signeture of Funerel Service Lice		Cedar	edar Hill Cemetery 3/3/99 Suitlan 22. Name and Address of Feellity Advent Funeral Services								
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	23a. Part1. Enter the disease, or cor shock, or heart feilure. List only	one cause on each li	the deeth. Do i	not enter the mod	de of dyll	ng, such es	cardiac o	or respiretory er	rest,		Approximete nterval Between Onset and Deeth	
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: After this e funeral d ation: To	27. Manner of Deeth 1 Neturel 5 Pending 2 Accident investigation	28e. Date of Inju (Month, De	ry 28b.		28c. Inju Wo			28d. Describe h				
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ompletely fii	29b. Signature and Me oxpertitier	N.										
	29b. Signature and Mile overritier	A			Da	965	7		2/28	3/99		

Registrar

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Physician /Medical Examiner

Physician

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Madical Exampler must be notified at

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with

death

permit. Peges 1 and 2 should be filled within 72 hours effer Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite

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other

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altimore, Maryland 21215-0020

/Medical

10a. State

Director

Funeral

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Completed

Examiner Physician/Medical 98 9SI ō Completed by Be 2 Certification:

physicien end the burief-trensit certificate be executed signed by t hes certificate After this funeral or Attending deeth 24 hours efter deet Funeral Director: filled in by Hospital To the I

Division of Vital Records, P.O. Box 68760,

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 1 Naturel
2 Accident 5 Pendina 1 Yes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 D Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner steted. 29a. Certifier (Check only one)

29c. License number

032036

Drive Chater, MD 21619

29d. Dete signed (Month, Day, Year)

State Registrar

Medical

29b. Signeture and title of certifier

31. Date filed (Month, Day, Yar)

MAR 0

30. Neme and eddress of

erson who completed cause of deeth (Item 23e) (Type, Print)

1999

25-199 . File

Please Type or Print in Biack Indeiible Ink. Assure Ali Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend. 7 3/2/99 SM AACO Health 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death 25 1999 Month FEB. **Physician** VELMA POUNDS 1705 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Hours 1 M 2 F 79 Yrs. 259-10-4327 Director 2 1920 GEORGIA Usual Residence of Decedent 10b. County 10c. City, Town or Location Show 10d. Inside City Limits r than "natural", or items 23s or 28s-f short the Medical Examiner must be notified at Director MARYLAND ANNE ARUNDEL **EDGEWATER** 17 Yas 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 137 TYDINGS DRIVE 21037 US Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forcas? 14. Race - American Indian, Bleck, White, etc. 72 hours after 1X) Yes 2 No
If Yes, Give 1:942-45
Year or Detes: 942-45 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK by 3 Widowed 4 Divorced Completed 16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiena. marked other than Elementery/Secondary (0-12) College (1-4or 5+) US NAVAL ACADEMY 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 Is marked other any lollury or other traumatic avant abda. 18. Mother's Name (First, Middle, Maiden Sumame) Be BENJAMIN POUNDS MATTIE TUFF 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) VIRGINIA POUNDS (WIFE) 137 TYDINGS DRIVE EDGEWATER, MD. 21037 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State ₩ Burial 2 Cramation 3 Removel from State ANNAPOLIS MEM. GARDENS 3/2/99 ANNAPOLIS, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service License 22. Name and Address of Facility
WM. REESE & SONS MORTUARY, P.A. Deese 821 WEST ST. ANNAPOLIS, MD. 23a. Pert1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or hear failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical fmmediate Cause (Finel Ducumonia week diseese or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner sician and burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): physician as the burial Box 68760 Physician/Medical Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. failure 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? or Attanding 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide filled in 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. edical To the Hosp within 24 ho To the Fune complately fi (Check only 29c. License number 29d. Date signed, (Month, Day, Year) 29b. Signature and title of certified D38128 26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 100, AMAPULII, MO 21401 MARZIO MD 2003 Medical State Registrar

Please Type or Print In Black indelible ink. Assure All Copies Are Legible.

				rtificate of	Death		Reg. No.	0.0	002
Physician	Decedent's Name (First, Middle, Last)					2. Data of De Month	eeth Dey	Yeer	3. Time of Death
/Medical	BESSIE E.					FEB. 2			1745
Examiner	4a Fecility Name (If not institution, giva				4b. City, Town, or L		th 4c. County	ol Death	
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vith the Ma t or 28a-f s be notified Director	10e. Streef end Number		-	10f. Zip Coda			10g. Citizen of W	/hat Countr	y?
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E 22 69 44	JAMES MASON (SON		702	K. NEW	TOWN DR	ANNA	POLIS,	MD.	21401
semil. Pages 1 a Department of Has reportant: if item my Injury or othe abox.	20a. Method of Disposition 1 □ Burial 2 □ Cramation 3 □ R		cemetery, cri	osition (Neme of emetory or other ple		Date	20c. Location -		
artman ortant: Injury	4 □ Donation 5 □ Other (Specify)		IILL C	REST CE	METERY	3/4/99	ANNAPO	LIS,	MD.
Departiment Insport	21. Signature of Funeral Service License	Leese	-		ess of Facility SE & SOI T ST. Al				0.1
Physician /Medical	23a. Part1. Enter tha dise e, or compl shock, or haart failure. List only or Immediate Ceuse (Final	ications that causad the dance cause on each line.	ath. Do not e	ntar tha mode of dyl	ng, such as cerdiad	or respiratory	arrest,	1	Approximata Interval Between Onset and Deeth
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or Attending Physician: The law requires t after death. Director: After this certificate has been signed in by the funeral director, page 2 should be ertification: To Be Completed by						10	Yes 2 No	1 🗆	Yes all No
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To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com		elclan: To the best of my kr ner: On tha basis of examinand manner stated.							
Nithin Fo the Sompl	29b. Signature and little of certifier			29c. Licen	se number		29d. Date signe	d (Month, E	Dey, Year)
->-0	VIK Phase	らじっ		04	7518		7-76	- 90	7
	30. Name and address of person who co	empteted ceuse of death (Ite	em 23e) (Type	p, Print)	7518 KUL+C	stred	SIT A	INAPI	ZIKO
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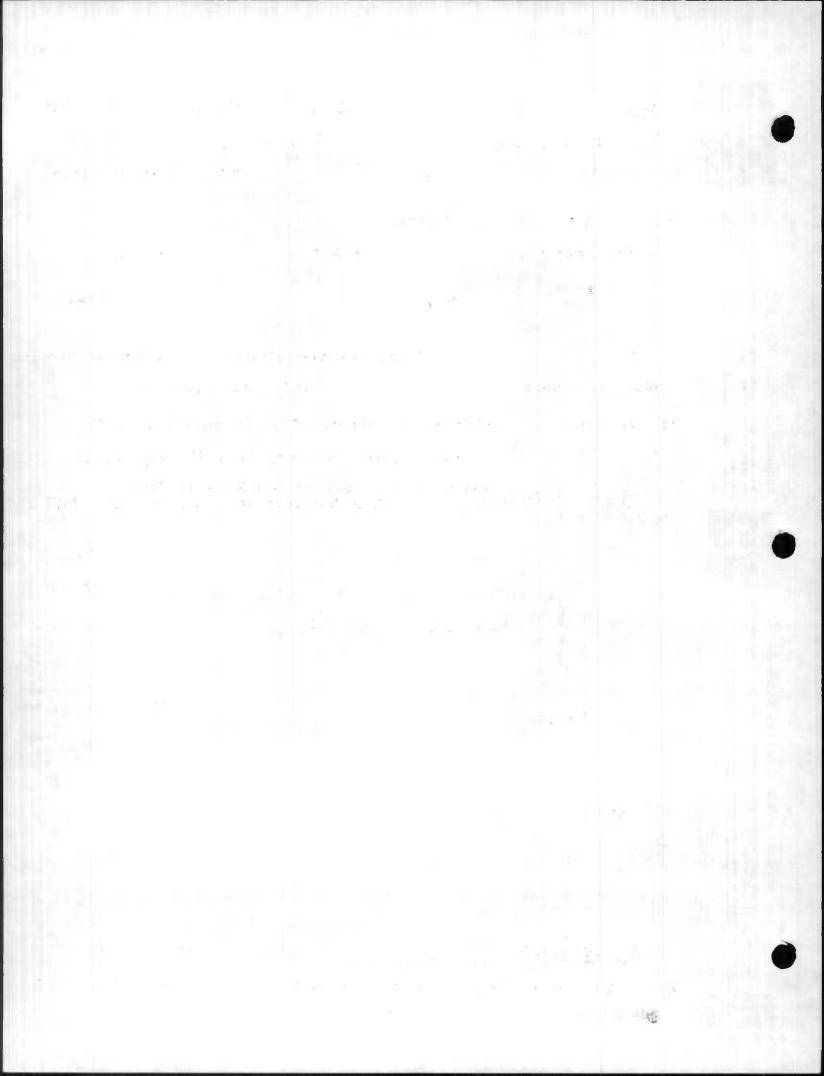
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State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1999 MARCH JOHN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) Examiner HOPKINS 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. JOHNS HOSPITAL 8. Date of Birth (Month, Day, Year)
Oct 24 1926 Pelaware Birthplace (State or Foreign Country) 5. Social Security Number 6. Sax **Funeral** Days Hours 1**X** M 2□ F 72 Yrs. Director 221-14-3638 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1X Yes 2 □ No Directo DE Kent Smyrna 10e. Streel and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examinat must be 416 Mulberry St. 19977 U.S.A. Pages 1 and 2 should be filled within 72 hours efter death nant of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural; or items 23. Funeral 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowad 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Administrative Clerk U.S. Postal Service 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be John H . Poore Lulu A. Davidson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Ila C. Poore (wife) 416 Mulberry St. other Smyrna, DE. 19977 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State = 6 Department of Important: If any injury or once. Odd Fellows Cemetery 3/11/99 Smyrna, DE. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Matthews-Bryson Funeral Home M00510123 W Commerce St. Smyrna, DE. 19977 of bons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onsel and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) OVERWARIMING SEPSK **Examiner** Due to (or as a consequence of): Examiner BILLARY OBSTRUCTION IL DAYS raw physician and the burial-transit Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): ANCREATIC ANCER DAYS Physician/Medical Due to (or as a consaquance of): Ses usa Por Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown signed b KENAL FAIWRE Division of Vital Records, 2q 24b. Were autopsy findings available prior fo 24a. Was an autopsy Completed complation of causa of death? has 2 No or Attending Physicien: funaral director, 25. Wes case referred to medical axaminar? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P ↑ Inpatient 2 □ ER/Outpatient 3 □ DOA this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending after death. 1 Yes 2 No Investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Streat and Number or Rural Route Number, City or Town, Stete) 4 Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical complately (Check only one) To the vithin 2 29b. Signature and titla of certifies 29c. Licansa number 29d. Data signed (Month, Day, Year) 5+IVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHNS HOPKINS HOSPITAL RICHOPO S. VOX, M.D. 600 N. WOLFE ST. BALTIMORE, MD ZIZ87 31. Date filed (Month, Day, Year)

MAR 0 8 1999 32. Registrar's Signature souks Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

If Under 1 Ye

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1999 ear March 4,

4b. City, Town, or Location of Death

If Under 24 Hrs.

12:45pm

4c. County of Death

Ceci1

Physician
/Medical
Examiner

CONSTANCE

5. Sociel Security Number

UNION HOSPITAL

MARIE

4e Facility Name (If not institution, give street and number)

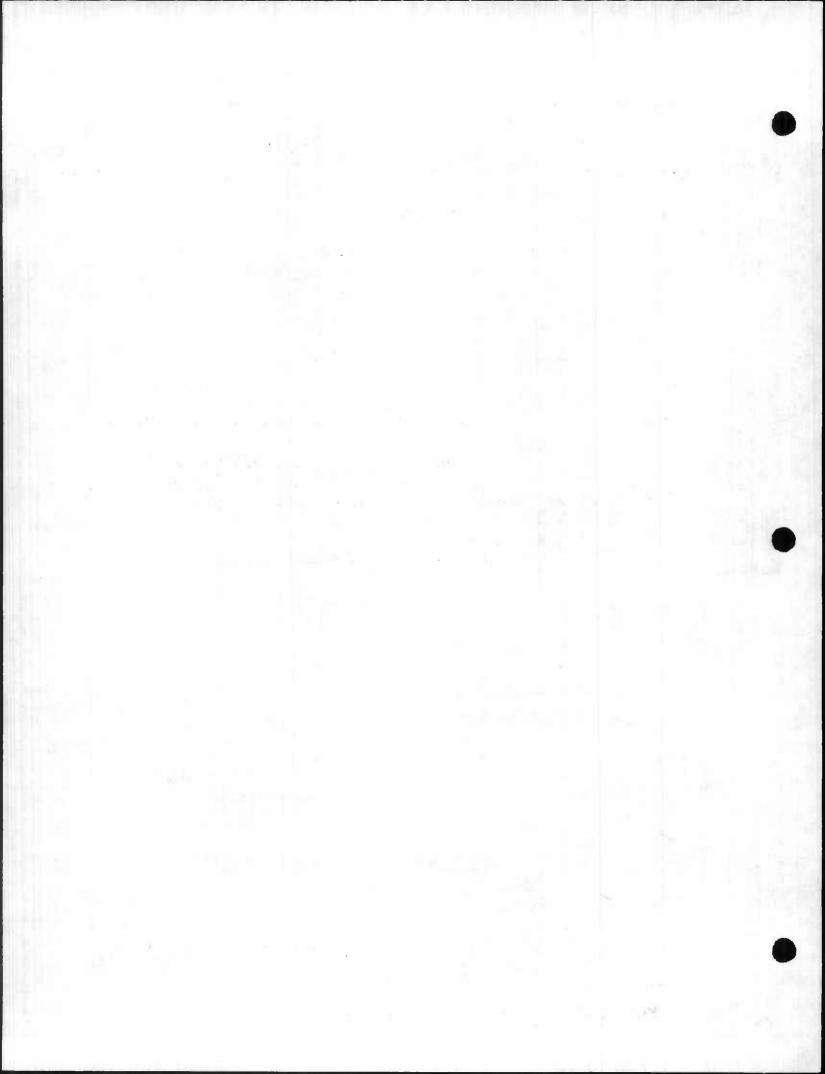
PIERCE

7. Age (In yrs. last birthday)

Funeral

8. Date of Birth (Month, Day, Ye Aug 3 1 Birthplace (State or Foreign Country) Days Hours 1 □ M 200 F Months 54 Aug 1944 Maryland Director 219-42-9387 Usual Residence of Deced 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location Ceci1 Warwick TX Yes 2 No MD Director 28a-f 96 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 21912 U.S.A. 176 East Main St. Nerna 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Stetus Black, White, etc. 72 hours after 1 ☐ Yes 21 No If Yes, Give 1 Never Married 2 Married 8 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Billing Clerk Medical 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental b Be Pages 1 and 2 should hent of Health and Men Edward Ford Margaret O'Grady 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a if Hem 27 is or other tra (husband) 176 East Main St. Warwick, MD. 21912 Thomas Pierce 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Old Bohemia Cemetery 3/9/99 Warwick, MD. 21. Signature of Funeral Service Licension 22. Name and Address of Facility Galena Funeral Home of Stephen Schaech M00510 118 W. Cross St. Galena, MD. 21635 23a Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final refastax ? elmina disease or condition resulting in death) Examiner Examiner sician and burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Box 68760 physician Physician/Medicai the Due to (or as a consequence of): 98 for use signed by the a P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No with telleronary by Records, The law requires 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2□ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA shis funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation Natural s after death. 1 TYes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide filled in Hospital 24 hours 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical completely (Check only within 2 the 29d. Date signed (Month, Day, Year) 29b. Signeture appl title of certifier 29c. License number cymo se of death (Item 23a) (Type, Print) 30. Name and address of person who ad P.O. BOX 670 MAR 0 8 1999 32. Registrar's State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Parker James Joseph 03 4:10 Pm 01 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Energency 7. Age (In yrs. lest birthday) If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Union Hospital Ceci1 5. Social Security Number Birthplece (Stete or Foreign Country) 1**№** M 2□ F Yrs. 87 165-01-7667 April 17 1911 Pennsylvani Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 ☐ Yes 2 No MD Ceci1 Earleville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 31 3rd Ave. 21919 U.S.A. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck. White, etc. Armed Forces 7

1XX Yes 2 No
If Yes, Give
Year or Dates: 1942 1 ☐ Never Married 2 ★ Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: White to 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) James Joseph Parker Sr. Regina Halpin 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Earleville, MD. 21919 Estella Parker (daughter) 31 3rd Ave. 20b. Pleca of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2X Cremetion 3 ☐ Removal from Stete Capitol Crematory 3/6/99 Dover, DE. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Galena Funeral Home of Stephen Schaech M00510 118 West Cross St. Galena, MD. or the distance, or complicetions that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest Immediate Ceuse (Final diseese or condition resulting in death) Cardiopulmonar Arrest. Due to (or es e consequenca of) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequença of): Pert II. Other significent conditione contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? 1 Yee 2 No 3 Probably 4 Unknown Hypertension 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Congestive Heart Failure 24a. Wes en eutopsy performed? Ischemic Transient 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2€ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f ahow be notified at Director

ŏ Items 23a

Funeral

by

Completed

the Maryland

death

should be filed within 72 hours after on Mental Hygiena.

marked other than "natural", or item

Pages 1 and 2 should be fill ment of Health and Mental High ant: If Item 27 Is marked oth

If item 27 or other tra

permit. Page Department of Important: If any Injury or once.

Baltimore, Maryland 21215-0020

Examiner that the death certificate be axecuted Box 68760. Physician/Medical P.O. Records, by Division of Vital Hospital or Attending Physicien: 24 hours after death. Funerel Director: After this certifice Be Certification: To

filled in by 24 hours a To the Hosp within 24 hor To the Fune completely fi OT IVA

> State Registrar

27. Menner of Deeth

Neturel 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signeture end title of certifier

5 Pending Investigation

6 Could not be determined

28e. Dete of Injury (Month, Day Year)

5208

28c. Injury et Work?

Scentifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated.

29c. License number

1 Yes 2 No

MD.

29d. Date signed (Month, Dey, Year)

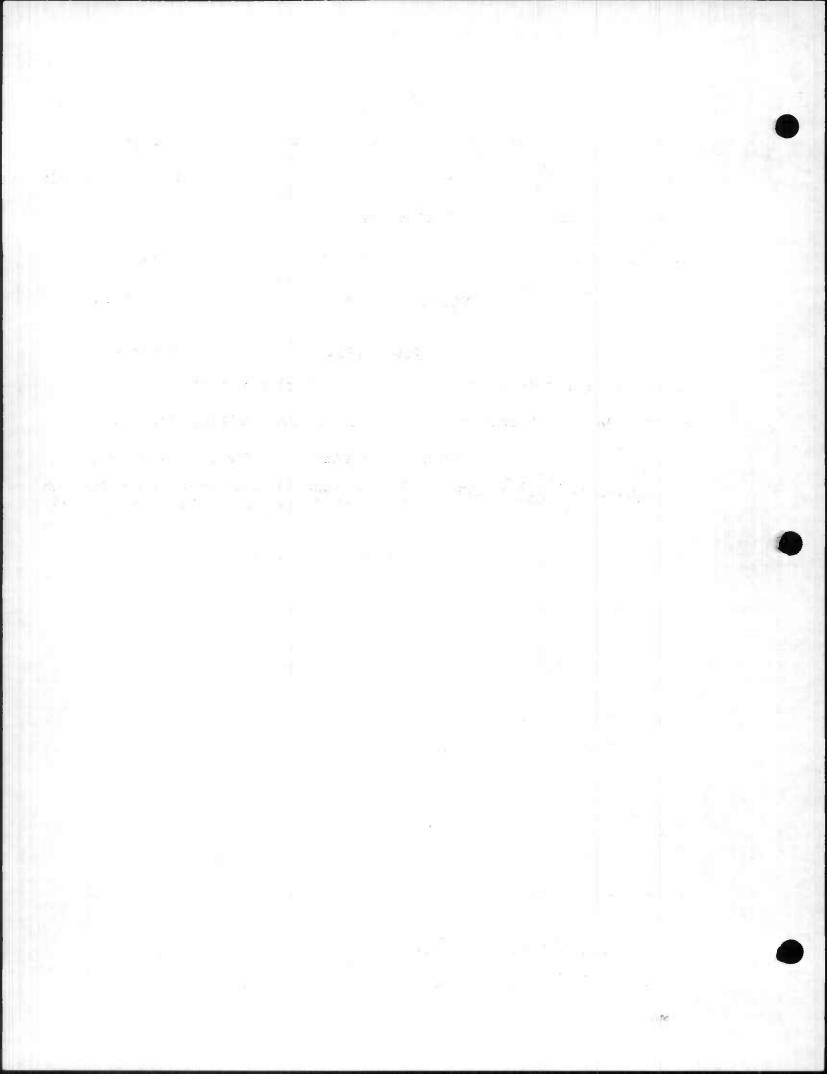
28f. Location (Street end Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

union Hospita 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Piarulli 106 Bow Stree J. Michael Elkhon Jumo

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

31. Dete filed (Month, Day, Year) 32. Registrer's Signature MAR 0 4 1999



71	•
State of Maryland / Department of Health and Menta	al Hygiene

	and the state of	Otato of Maryin		cate of	Death	F	Reg. No.	088	43	
Physician	Decedent's Nama (First, Middle, Last					2. Data of Dea Month	ith Day	3. Tir	na of Death	
· /Medical	NETTYE	PRIMME	?			02	07 99	5	P.M.	
Examiner	4a Facility Nema (If not institution, give	street and number)			4b. City, Town, or	Location of Death	4c. County	of Death		
	Wheaton Manor	Health Car			Wheaton					
Funeral Director	5. Social Sacurity Number 6. S 577-22-1517 Usual Residence of Decedent	ex 7. Aga (In y.		nder 1 Year hths Days	Hours Min.	8. Date of Birth (Month, Dey 6/12/1		9. Birthpiaca (Si Country) N . C .	tete or Foreign	
pue *	10a. Stete 10b. County	10c.	City, Town or Location					10d. Insi	de City Limits	
be filed within 72 hours after deeth with the Maryland all Hydren. Its Hydren. On terms 23a or 28a-f show event, the Madical Exameter must be notified as event, the Madical Exameter must be notified. Be Completed by Funeral Director	D.C.	Wa	shingtor	1					Yes 2□No	
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3a c	1350 Taylor S	L. N.W.		2001	1		U.S.A.			
ms in	11. Maritai Status	12. Wes Decedent Ever in Armed Forcas?	U,S. 13. Wes [dispanic Origin? (S an, Mexican, Puerl	pecity Yes or No-		e - American India	an,	
ital hydiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examerer must be notified at event, the Medical Examerer must be notified at event.	1 Never Married 2 Married 3 XWidowed 4 Divorcad	1 Yes 2 No If Yes, Give Year or Dates:		es XXNo	Specify:	o racan, etc.)		Black		
ygiene. or then "natural, the Medical Completed	15. Decedent's Ed		16a. Decedent's	Usual Occup						
pie	(Specify only highest gre	College (1-4cr 5+)	life. DO N	OT use retire	d) most of wor	King				
r than		4	Elavat	or O	Operator Government					
a other of other of other of other of other of other o	17. Fathar's Name (First, Middla, Last)				18. Mother's Ner	ne (First, Middle,	Malden Sumen	10)		
and Mental Hygiene. Is marked other than aumatic event, the M	William H. Fu.	ller			Bettie Mayo					
traumatic	19e. Informent's Name/Reletionship (1	Type, Print)	19b. Mailing Ad	dress (Street	end Number or Ru	ral Route Numbe	r, City or Town,	Stete, Zip Code)		
	Barbara Braxton neice 1903 Elton Rd. Adelphi, Md. 20783									
7 5 5	20a. Method of Disposition		. Place of Disposition cametery, cremetory	(Neme of		Date			ita	
nent of 1	1 Surial 2 □ Cremation 3 □ 4 □ Donetion 5 □ Other (Specify		· · · · · · · · · · · · · · · · · · ·			2/11/00	20c. Location - City or Town, Stata			
트린글	21. Signatur Funeral Service Licen				es of Facility		1/99 Suitland, Md.			
Impo Impo Ince	The state of the s	Edin				Hodges				
	23a. Pan1. Enter tha disaasa, or comp	Culture			ver Hil			nd, Md.2	0746	
g physician and as the burial-transit	resulting in death) Sequentially list conditions	Due to (or as a consequenca of): b Due to (or as a consequenca of):								
physician end is the burial-transit edical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Undertyling Cause (Disease or Injury thet initiated events Due to (or as a consequence of):									
	resulting in death) Last	d.	(or as a consequence	1 01):				1		
to the death cert d by the attendin letached for use Physician/N	Dort II. Other significant conditions of	antilla attack and antilla attack		lan sawas ab	una la Dant I	OSP Did a		ntribute to the ca	use of death!	
ed by the a detached to Physic	Part II. Other significant conditions co	ontributing to death but not i	esulting in the underly	ing cause gr	ven in Part I.			3 Probably	4 Unknow	
igned be deta	DEHYDRATION,	MALNUTRITIO	ON				res 2/1 No	3 Trobably	4 Olikilow	
sate has been si pege 2 should					1		an autopsy med?	24b. Were auto available p completion of death?	opsy findings orior to n of cause	
ate has been signed by the page 2 should be detache.						1 D Y	es 2 No	1 ☐ Yes	2 No	
	25. Was case raferred to medical				26. Place of De	eth (Check only o	ne)	1		
4 5	axa <i>m</i> iner? 1 ☐ Yes ❖☐ No	Hospitel: 1 Inpatient 2	☐ ER/Outpatient 3[DOA Ott	ner:	lome 5 Resid		ar (Specify)		
eral d	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Inju	ry at	28d. Describe h				
th. After e funer	XXNatural 5 Pending 2 Accident Investigation	(Month, Dey Year,	Injury N	Wo 1□	rk? Yes 2□No					
within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, street, fa	actory, office		28f. Location (5 City or Tow	Streat and Numb m, Stete)	per or Rural Route	Number,	
tely fill		ysician: To the best of my kiner: On the besis of exeminand menner steted.							use(s)	
within 2 comple	29b. Signature and title of certifier			29c. Licens	sa nu <i>m</i> ber		29d. Data signe	d (Month, Dey, Ye	987)	
	> 4. Ch	ullem	518	FEBRUARY 23, 199						
(6)	30. Name and address of person who coul Chablan	completed cause of death (I	tem 23a) (Type, Print)	1119	Rockvi1	le Pike	e#316	20892 Rockvil	le,MD	
State	31. Date filed (Month, Dey, Yeer)	2. Registrar's Sig	grature							

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend item #5.Per FH PGC 3-12-99 cr 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month 6:10 PM Feb. Cora Partridge

4a. Facility Name (If not Institution, giva street end number) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 411 Tulip Ave., Takoma Park Takoma Park Montgomery 5. Social Security Number If Undar 1 Year If Undar 24 Hrs. 7. Aga (In yrs. lest birthday) 8. Data of Birth (Month, Dey, Year) **Funeral** Birthplaca (Stete or Foreign Country) Months Days Hours 1□M 20F <u>036-26</u>-6311 Yrs. Director 82 20, 1916 Dec. Alabama Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examiner must be notified at MD Montgomery Director 1 Yes XX No Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? ò Items 23a 411 Tulip Ave. USA death Funerai 20912 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Orlgln? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Medical Exercise. 1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify:White by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade com 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry completed) College (1-4or 5+) Elementary/Secondary (0-12) Writer Publishing 17. Fathar's Name (First, Middle, Lest) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Franklin Chenev Irene Denny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Benjamin Partridge/Husband 411 Tulip Ave., Takoma Park, 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State Metropolitan Crematory 2/23/99 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Takoma Funeral Home 21. Signature of Funeral Servica Licensee 254 Carroll Street NW, Washington, DC 20012 23a. Part1. Enfer the disaasa, of complications that ceused tha death. Do not enter tha mode of dying, such as cardiac or respiratory arrast, shock, of haart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final Left Hemorrhagic Stroke disease or condition resulting in deeth) 2 weeks Examiner Due to (or as a consequence of): Physiclan/Medical Examiner Hypertension 3 years The law requires that the death certificete be executed the buriel-transit Sequentially list conditions, if any, laading to immediate ceuse. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last Due to (or as a consequence of): physician Due to (or as a consequence of): SB **HSP** for ate has been signed by the a page 2 should be detached t Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yas 2 ☐ No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? 2 No certificate 1 TYes 1 □ Vas 2 □ No 25. Was cese referred to medical 26. Place of Death (Check only one) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No OL 27. Manner of Death Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending Invastigation Injun 1 Yes 2 No 2 Accidant 3 Suicide 6 Could not be determined

P.O. Box 68760. Division of Vital Records,

spltaf or Attending Physician: Theoris after death.

nerel Director: After this certificate y filled in by the funerel director, pa Hospital 24 hours

completely To the I within 2

State

29b. Signature and

29a. Certifier

Medicai

4 Homicide

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the course. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. of certifie

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

29c. Licansa number D21900

20912

29d. Data signed (Month, Dey, Yeer) February 22, 1999

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print)

7610 Carroll Ave. #280 Takoma Park, MD Smith Ho 31. Date filed (Month, Day, Year) MAR 0 2 1999

32. Registrar's Signature

Registrar

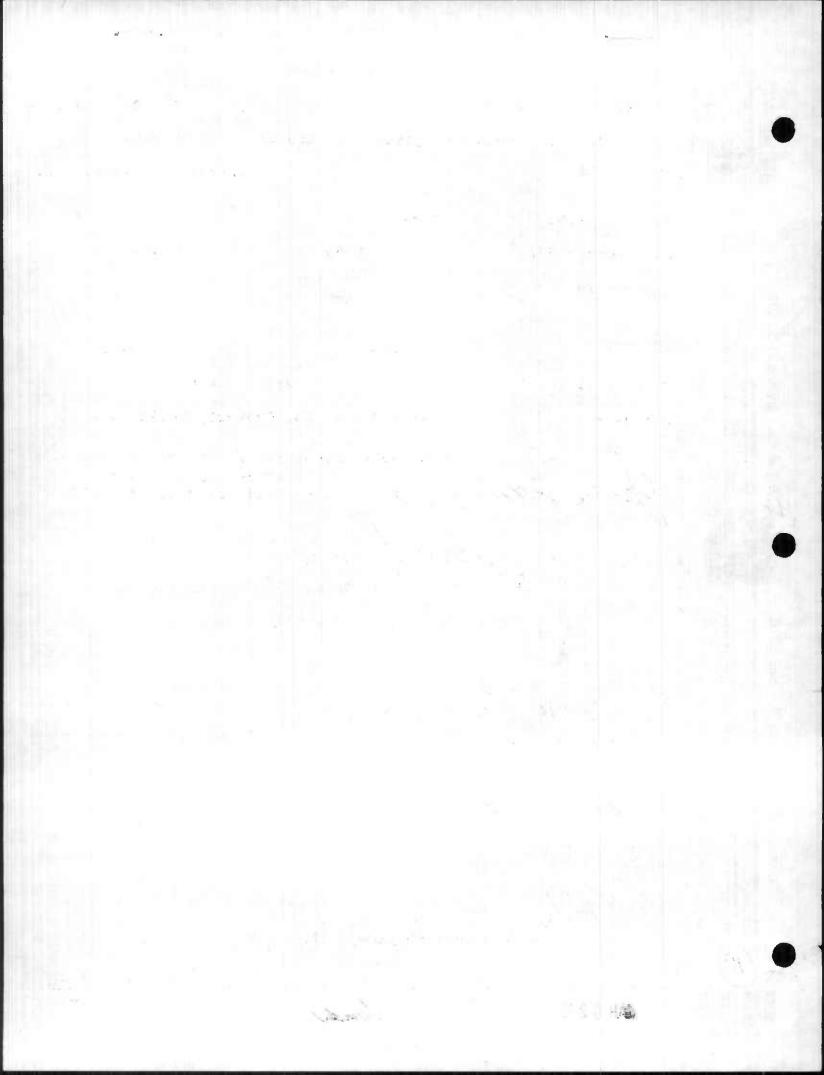
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death Baitimore, Maryland 21215-0020 Pages 1 and 2 should be filed within 7 and Mental Hygiene.
Intel Hem 27 is marked other than "r
iny or other treumatic event, in a Med hysician and the burial-transit that the death certificate be executed P.O. Box 68760. physician 88 USB Po signed be del

Physician 12:05am **JAMES** /Medical 4a Facility Name (If not institution, give street and number) Examiner Prince Georges General Hospital 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 578-50-8666 Director D.C. Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 7 is marked other than "naturel", or items 23s or 28s-f show treumstic event, it a Medical Examiner mast be notified at 1 Ves 2 □ No Director MD 10e. Street and Number 6455 Forest Rd. Funeral 11. Marital Status 1 Nevar Married 2 Married by 3 ☐ Widowed 4 ☐ Divorced Completed Elementary/Secondary (0-12) 17. Father's Neme (First, Middle, Last) Grace Bonds James Pollard 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6455 Forest Rd. Cheverly, Md. 20785 Ruth Harrod 20b. Place of Disposition (Neme of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 3/6/99 Beltsville, Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Addrass of Facility Hodges and Edwards 21. Signature of Funeral Service Licenses 3910 Silver Hill Rd.Suitland, Md. 20746 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Vancea Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Physician/Medical Dua to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yss 28 No 3 Probably 4 Unknown Division of Vital Records, P 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy dialy completion of causa of death? has page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: director. 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient P 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? After 5 Pending Investigation s after death. 1 Yes 2 🗆 No 2 Accident 3 Sulcida 6 Could not be 28f. Location (Straet and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) in by 4 T Homicide 24 hours a Cerultying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as steled.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier To the I within 2 To the I complet 29d. Data signed (Month, Day, Year) 29c. License number 29b. Signature and titl wh 36 Name and address of person who completed cause of death (Item 23a) (Type, Print) CENTRE DRIVE GREENBELTMA GREENWAY KISHPAL INGH 31. Date filad (Month, Dey, Yeer) 32 Registrar's Signature State MAR 0 2 1999 Registrar



BALTIMORE, MARYLAND 21215-0020

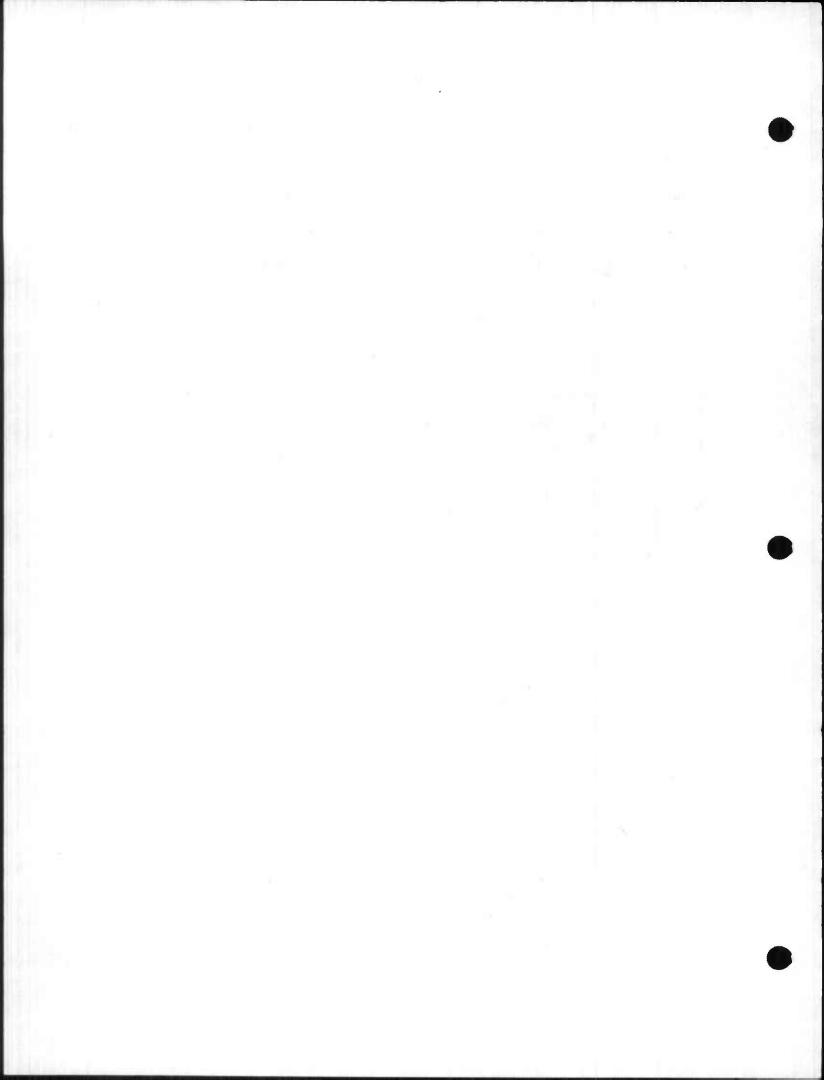
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or remoral.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

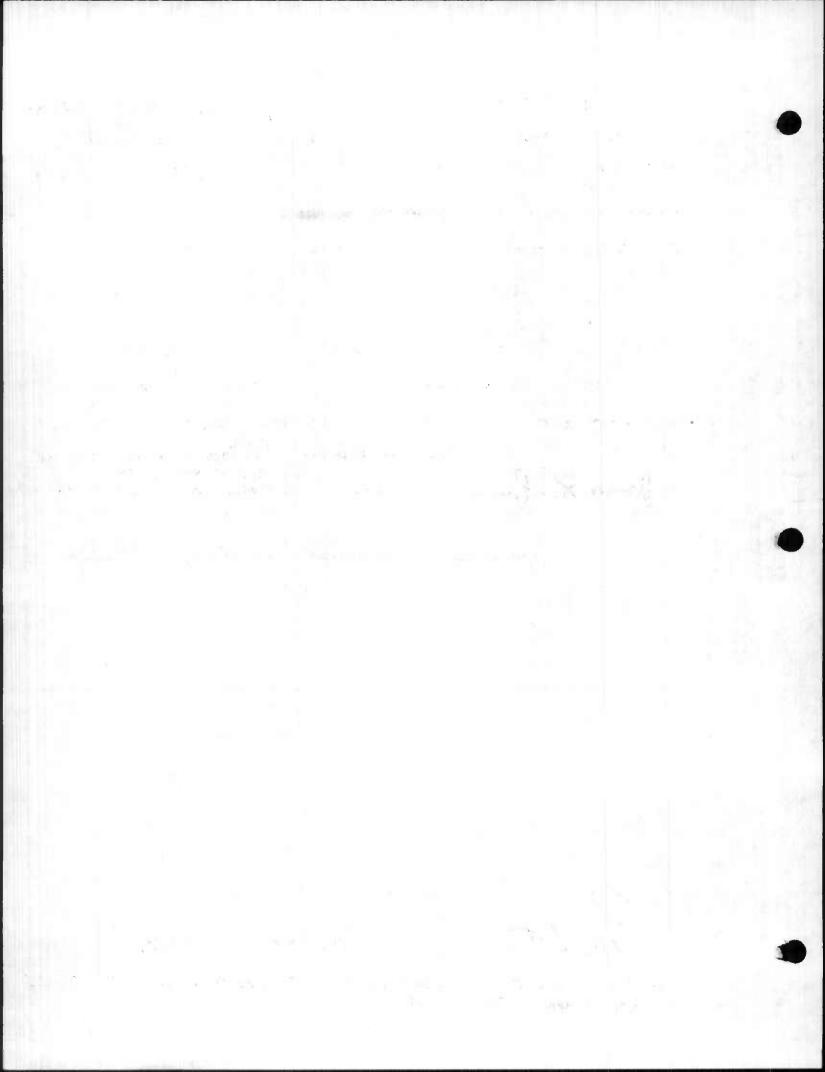
	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND		TMENT OF I		MENTAL HYGIEN		00040					
,	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH					
	Wilbur Plummer PRIC	CE				MARCH	8 199	9 1:00 A. M					
	4. SOCIAL SECURITY NUMBER 5.	SEX 6. AGE (In yrs. Id	est birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	. 7. DATE OF BIRTH 8. BIRTHPLACE (State of							
	217-12-2009	X□ M 2 □ F 78	YRS.	MONTHS DAYS	HOURS MIN.	July 28,	1920 1	Maryland					
05	Se. FACILITY NAME (if not institution, give street			96, CITY, TOWN	OR LOCATION OF DE	EATH	9c. COUNTY	OF DEATH					
DIRECTOR	11 S. Walnut Street	t Apt. 313		Hag	erstown		Washington						
H	10s. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCA	TION		10d. INS						
	Maryland Washing	gton		Hagers			1 X YES 2 NO						
FUNERAL	10e. STREET AND NUMBER			10	I. ZIP CODE			OF WHAT COUNTRY?					
NE	11 S. Walnut Street	Apt. 313	D1150	140 000 00	21740		U.S.						
	1 Never Married 2 Merried	FORCES? 1 X YES 2 FIF YES, GIVE WAR OR DATES	NO	If yee, a	ecify Cuben, Mexice	IIC ORIGIN? (Specify Year, Puerlo Rican, etc.)	e or No— 14.	. RACE — American Indian, Black, White, atc.					
84	3 Widowed 4 X Divorced	W. W. T	т	1 1 1 1 1	NO Specify	f:		Specify: White					
COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade con	ION 16a. D	ECEDENT'S	USUAL OCCUPATI		16b. KIND OF BU	SINESS/INOUS						
E		College (1-4 or 5+)	te. Do NOT us	se retired.)									
MP	6	0	Owner	/Operat		Grocer		е					
	17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Millard I Price Liggio F Plummor												
BE	Millard J. Price Lizzie E. Plummer 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number of Burel Burels Number City of Every State 7th Code)												
0	196. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 14000 Karner Road Mercershurg Pa. 17236												
	Segerna Davis/Daughter-in-law 14000 Karper Road Mercersburg, Pa. 17236 200. METHOD OF DISPOSITION 200. PLACE AND DATE OF DISPOSITION OATE 200. LOCATION — City of Town, State												
	1 (X) Buriel 2 Cremation 3 Removal from State cametery, crematory or other place) 4 Donation 5 Other (Specify) Cedar Lawn Memorial Park 3/11/99 Hagerstown, Maryland												
	22. NAME AND ADDRESS OF FACILITY MIDDICH FUNETAL HOME												
	> James L. X	Cicu		415	E. Wilson	Blvd. H	agerst	own, Md.					
	23. PART /. Enter the diseases, or com	plications that caused the	death. Do r	not enter the me	ode of dying, auc	h sa cardiac or resp	Iratory arrest	1, Approximate					
	shock, or heart fellure. Lies	t only one cause on each lin	16.					Interval Between Onset and Death					
	disease or condition												
	readiting in death) . e	DUE TO (OR AS A COMS	EOUENCE O	F):	1			immediah					
N	Sequentially list conditions b.												
MI	Sequentielly list conditions, if any, leading to immediate Due to (or as a consequence of):												
FIC	CAUSE (Disease or Injury												
CERTIFICATION	thet initiated eventa reaulting in deeth) LAST												
	d												
AL	PART II. Other algnificant conditions of	ha	resulting	in the underlyin	g cause given in	Part I. 24s. WAS AN PERFO		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO					
DIG	179,00	Lyrordism				1 YES :	2 NO	OF DEATH?					
ME	DID TOP ACCOUNT CONTROL	ife lower of Dr	ATLL VI	C EL NO E	1 UNICEDTAN			1 TYES 2 NO					
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRÍB 25. WAS CASE REFERREO TO MEDICAL			TH (Check only one	UNCERTAIL	N L							
SICI	EXAMINER?	OSPITAL:		OTHER:	no E N Busidana	6 Other (Specify)							
H	27. MANNER OF OEATH	28e. OATE OF INJURY	28b. TIM	IE OF 28c. IN	JURY AT	28d. OESCRIBE HOW	INJURY OCCUR	REO					
ВУ Р	1 Natural 5 Pending	(Month, Day, Year)	IN.	M 1	YES 2 NO								
	2 Accident Investigation 3 Suicide 6 Could not be	26e. PLACE OF INJURY — At I building, etc. (Specify)	home, tarm,	street, fectory, offi	Pe .	281. LOCATION (Street City or Town, Stete	and Number or	Rural Route Number,					
TED	4 Homicide determined					ony or rown, oreig	,						
COMPLET	290. CERTIFIER (Check only	N: To the best of my knowledge,	death occurr	ed at the time, dat	end place, and due	to the cause(a) and ma	nner se stated,						
OM	one) 2 MEDICAL EXAMINER: (On the beels of examination and/o	r investigation	on, in my opinion,	death occured at the	time, date end place, er	nd due to the c	ause(e) and menner ee stated.					
	2 MEDICAL EXAMINER: On the beels of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) and menner se stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Dey, Year)												
O BE	MARCH 8, 1985												
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) AMNUTY SRIMAD.												
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE	1, "	1 4									
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State of Maryland / Department of Health and Mental Hygiene

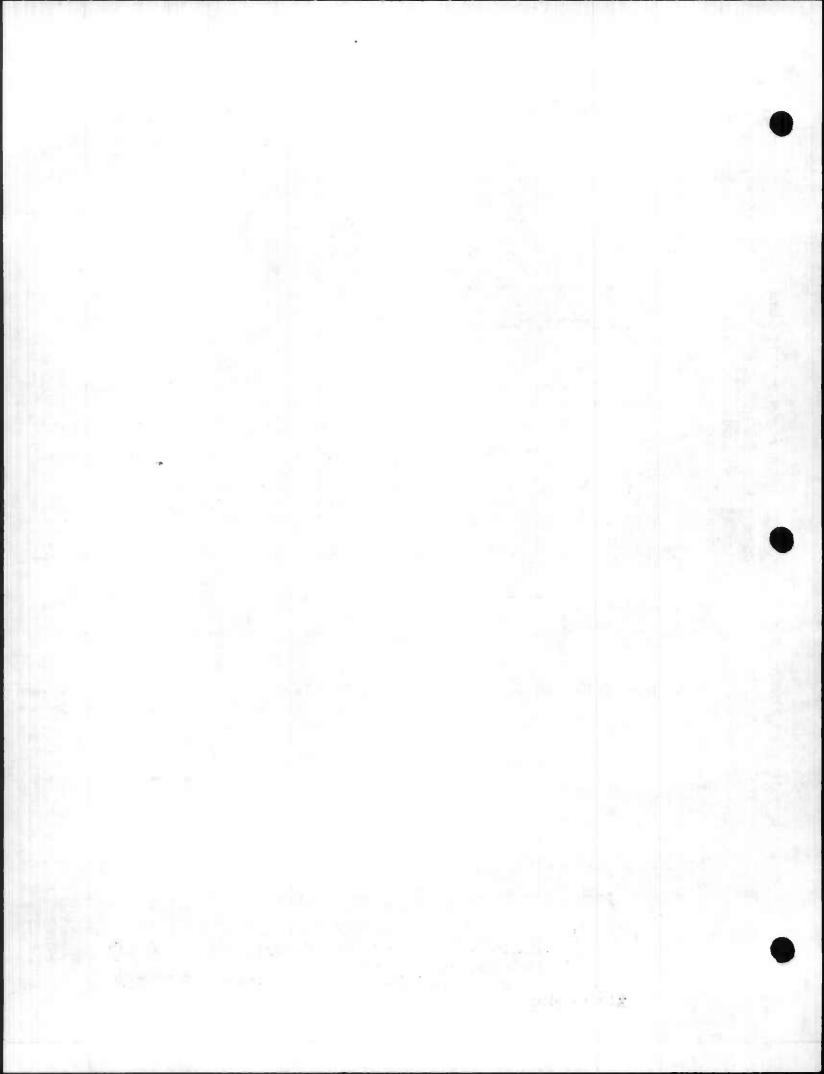
												Reg. No.		
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/Medica	_	Kut	1 D	eatrice	PECK						March			8:45
Examine	_	4e. Facility Neme (If not instit	ution, giv	e street end nur	nber)				4b. City, To	own, or L	ocation of Death			
		Reeders Memo	ria1	Home					Воо	nsbo	ro	Was	hington	n
Funeral Director		5. Social Security Number 219-12-0548	6. S	Sex I□M 2⊠F	7. Age (In yr.	s. lest birth	Mont	nder 1 Year hs Days		24 Hrs. Min.	8. Date of Birt (Month, De) Oct. 5	h v. Yeer)	9. Birthpiece Country)	Sylvani
		Usuei Residence of Deceden										, 1713	2 CHILL) I vani
a-f show	ctor	Maryland Was	_{inty} hing	ton			or Location rstown						10d.	Inside City Lin
23a or 28	Funeral Director	10e. Street and Number 12 South Wal	nut	Street			10f.	M. Zip Code 10g. Citizen of What Country? U.S.A.					7	
	þ	11. Marital Status 1 □ Never Married 2 □ Nover Married 2 □ Nover Married 2 □ Divor		12. Was Dece Armed For 1 Tyes If Yes, Give Year or De	rces? 2 🖾 No e	U,S.			Hispanic Or ben, Mexicar Specify:		ecify Yes or No- Rican, etc.)	ce - American I ck, White, etc. by: White	Indian,	
least .	ted	15. Dece (Specify only his	dent's Ed	ducetion		18e. D	Decedent's U	Isual Occu	pation	ation during most of working		16b. Kind of B	lusiness/Indust	ry
or realize marked other than 'r	Completed	Elementary/Secondary (0-1 0-12	-	Coilege (1-	-4or 5+)		life. DO NO	Tuse retire	ed)	t of work	ing	own home		
office of	Bec	17. Fether's Name (First, Mide	lle, Last)						18. Mothe	er's Name	(First, Middle,			
ic sed	LOB	Cha	rles		Robin	son								
E E		19a. Informant's Name/Relati	onship (Type, Print)			19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code)							
27 is		David L. Peck	0	ion										
y or othe		David L. Peck - Son 3641 Cherry Creek Drive Conyers, Ga. 30208 20a. Method of Disposition 1											Stete	
o Tro	- 1		17	1/					ess of Fecilit		innich			
Important: If III		23a. Pert1. Enter the disease shock, or heart feilure.					et enter the n	node of dyi	ng, such as	cerdlec		rest,	Ap	proximete ervel Between
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State of Maryland / Department of Health and Mental Hygiene 9 9 8 4 8

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Phys		Mary Ja	ane Quick						Month	2. 199	Yaer G	2:55 P.M.			
Exan	dical niner	4a Facility Nama (If not institution, giv			4		4b. City, To	wn, or Lo	ocation of Death		y of Death				
4		Anne Arundel Medi	ical Center				Annap	olis		Anne	Arun	del			
Funera	al	5. Social Security Number 6. 5	Sex 7. Aga	(In yrs. last birth		r 1 Yaar Days			D Date of Die	4.		place (Stata or Foraign ntry)			
Directo		217-05-3743 Usuel Residance of Decedant	□M 2XXF 85	Y	rs. Months	Months Days Hours Min. Aug. 30,1913 Connecticut									
ylen ylen		10a. State 10b. County	1	10c. City, Town	or Location							10d. Insida City Limits			
the Mar 28a-f si	Director	Maryland Anne Anne Anne Anne Anne Anne Anne An	cundel		Annapol	is o Coda				10g. Citizen of	What Cou	1 💢 Yes 2 🗆 No			
ath with 23s or	eral Dir	210-B Hilltop Lar	-		21	403					USA				
Maryland 21215-0020 d 2 should be filed within 72 hours after death with the Maryland th and Meniel Hygiene. 7 is marked other than "netural", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified.	by Funeral	11. Marital Status 1 □ Navar Marriad 2 □ Merried 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forcas? 1 Yes 2 No If Yas, Giva Yaar or Datas:		13. Was Dece				ecify Yas or No Ricen, etc.)	Speci	ack, White,	cen Indian, , atc. ite			
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Baltimore, permit. Pages 1 ar Department of Heal Important: If Nem 2 any Injury or other	buce	21. Signatury of Fungray Syryhog Licer	1589		22. Nama a	nd Addra	ass of Facili	ty							
n ases	a	George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater,													
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Physicia	,	shock, or heert failura. List only	ona causa on each line.								1	Intarval Between Onset and Death			
/Medica		Immediata Causa (Final		1)							2.1.			
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ding P. After funer	On	27. Manner of Death 1 SHatural 5 ☐ Pending	28a. Data of Injury (Month, Day)	rear) 28b. Ti		28c. Inju Wo			28d. Dascribe	now injury occi	irred				
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or Attending after death. Director: After din by the fune	Certification:	4 Homicide determined	28e. Place of Injury building, etc.	y · At homa, fan (Specify)	m, street, fecto	ry, office			28f. Location (: City or Tox	Street and Nun vn. Stete)	iber or Rui	ral Routa Number,			
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DIVISION OF To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29e. Cartifliar (Check only one) (Check									stated. to tha cause(s)				
To the Within 2 To the comple	×	29b. Signature and titla of contiliar			29	c. Licens	se number			29d. Data sign	ed (Month	, Day, Year)			
- x F 0		1 y O X	Purson		122006					29d. Data signed (Month, Day, Year)					
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S Regis	tate strar	marr/0-5 19	99 32. Registrar	1	9. 1	20. 4	,								



State of Maryland / Department of Health and Mental Hygiene

_	1109-310					- Waryiai				Death	45.7	Reg. No. 9	0	381	9
П	Physician		1. Decedent's Name								2. Date of D Month	Dey	Year	3. Time	
	/Medical	ŀ	John F. Ia Facility Name (If	~ 3	1	nher)	-01			4b. City, Town, or	FEBRUA		1999	2158	PM
	Examiner		ST. AGNE							BALTIMORE	37/3				
ľ	Funeral Director		5. Social Security No. 202–16–1	umber 6.5		7. Age (In yrs. 73		Month	ler 1 Year	if Under 24 Hrs		th av. Year) 192!	9. Birthple Count Pen	ace (Stete	or Foreign
ì	the Maryland 28a-f show		Usual Residence of 10a. State MD	Decedent 10b. County Anne Ar	rundel		ity, Town or Verna		•						City Limits
	ifier deeth with the Mai w theme 23s or 28s-f single direct must be notified Funeral Director		10e. Street and Num 211 Sycam					101. 2	Zip Code	21146		10g. Citizen of What Country? USA			Tip
020	0 0 0		11. Marital Status 1 Never Marrie 3 Wildowed	ed 2 Married	12. Was Dece Armed Fo 1 Types If Yes, Giv Year or De	2 No		_	Vas Decedent of Hispenic Origin? (Specify Yes of Yes, specify Cuban, Mexican, Puerto Rican, etc			or No- 14. Race - American Indian, Black, White, etc. Specify: White			
21215-0020	s 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. Item 27 is marked other than "natural", cother traumatic event, the Medical Executed that To Bio Completed by		(Speci	15. Decedent's E ify only highest grandary (0-12)	ducation ade completed) College (1	-4or 5+)	(G.		work done use retin	during most of wo ed)	rking	16b. Kind of B			
Maryland 2	buld be filed with Mental Hygiene sreed other than atic event, inc.		17. Father's Name (First, Middle, Last	2)		0.5	ALI	Y, Re	*	me (First, Middle Sokol	U.S. e, Maiden Sumer	Gover:	nment	
37	2 should and Men is marke aumatic		19a. Informant's Na	me/Relationship	(Type, Print)		19b. M	19b. Mailing Address (Street and Number or Rural Route Number, City or Town,						Code)	
	1 end 2: Health ar am 27 is ther trau		Jonathan	Quigg /	son		211	Sycan	nore	ore Road, Severna Park, MD 21146					
Baltimore,	00	2		osition Cremation 3 [State Ar	Place of Dis cametery, o	remetory o	(Neme of or other pleca) Arlington, VA						
Balt	permit. Pag Department Important: It any Injury o		21. Signature of Fin 21. Signature of Fin 22. Party Enter the	///	<		5	Barra	anco	& Sons,					
x 68760,	hysician / Medical Examiner as the buria-transit as		Immediate Cause (I disease or condition resulting in deeth) Sequentially list con if eny, leading to Im- cause. Enter Under Cause (Disease or it that initiated events resulting in death) L	nditions, mediate rlying njury	a b	f(x)	iviex								
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R	0 - 0 -										15	Yes 2□No	15	Yes 2	□ No
/ita	certificate rector, peg		25. Was case referr examiner?	ed to medical							eth (Check only	one)			
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no	After 1 funeral funera	1	27. Menner of Death 1 □ Natural	5 Pending		h, Dey Year)	28b. Time Injur		28c. Inje			how Injury occu		baen	
Division	To the Hospital or Attanding Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (2 Accident 3 Suicide 4 Homicide	Investigation 6 Could not be determined	28e. Placa buildin	of Injury - At h	ome, farm,			1 Yes 2 No Publica 28f. Locatio		or vehicle Cellison ion (Street and Number or Rural Route Number, Town, Stele) 952 P95			
	the Hospita ithin 24 hours the Funeral ampletely filled				nyeiclan: To the miner: On the ba					ime, date and plac opinion, death occ					e(s)
	To the comple	1	29b. Signature and	of certifier	Ond main	20		1	29c. Licer	se number		29d. Date sign	ed (Month, I	Dey, Year,)
			No Nome on A	eun	~ 2(huk	40 m 22a) (T	no Print)	C	CME		MARCH 1	, 199	9	
			30. Nempand addre	ess of person who	hute	113	l Penr		eet,	Baltimor	e, Mary	land 212	01		
	State Registrar	1	31. Date filed (Mont			egistrar's Sign	ature	4.	bou						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Day ROSETTA **EMMA** ELLEN 1999 0700 March 4e. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Dorchester Cambridge Chesapeake Woods Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Aug. 22 1915 5. Social Security Number 9. Birthplace (Stete or Foreign Country) Mary Land 1□M 25F 217-10-8471 Usual Residence of Decedent 10a Stete 10b County 10c, City, Town or Location 10d. inside City Limits Cambridge 12 Yes 2 No Dorchester 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21613 U.S.A. 305 Aurora St. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Yeer or Dates: 11. Meritai Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced white 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) garment mfg. sewing machine operator 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Sarah Amanda Hubbard Rhea Robert **James** 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1012 Greenway Drive, Cambridge MD 21613 Audrey Sammons - niece 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Burial 2 Cremation 3 Removal from State Dorchester Memorial Park 3-8-99 Cambridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Thomas Funeral Home PA 700 Locust St. Cambridge MD 21613 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onsei end Deeth congestive Cardiomyopathy Immediate Cause (Final disease or condition resulting in deeth) Sequentielly list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as e consequence of) Pert II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contributa to the cause of death? Cerebro Vascerla 1 Yes 2 No 3 Probably 4 Unknown occiden -24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? 1 ☐ Yes 2.12No 1 Yes 2 No 25. Was case referred to medical 26. Plece of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident

Examiner physician and s the burial-transit the death certificate be axecuted P.O. Box 68760. the 88 signed by the a certificate has Division of Vital this Aftar or Attending after death. To the Hospital of within 24 hours af To the Funeral D completaly filled is

Be P Certification:

cal

Physician/Medical þ Completed

Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Funeral

Director

must be r

than "natural", or items the Medical Examiner m

Hygiene.

Pages 1 and 2 should be filled w timent of Health and Mental Hygie riant: if Item 27 is marked other it slury or other traumatic event, it

Department of Health important: If Nem 27

Physician

/Medical

altimore, Maryland 21215-0020

1 Yes 2 No 27. Menner of Deeth

3 Suicide

29a. Certifier

4 Homicide

(Check only

6 Could not be determined

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

CAMBRIDGE MD 2/6/3

29b. Signature end title of certifies

MD

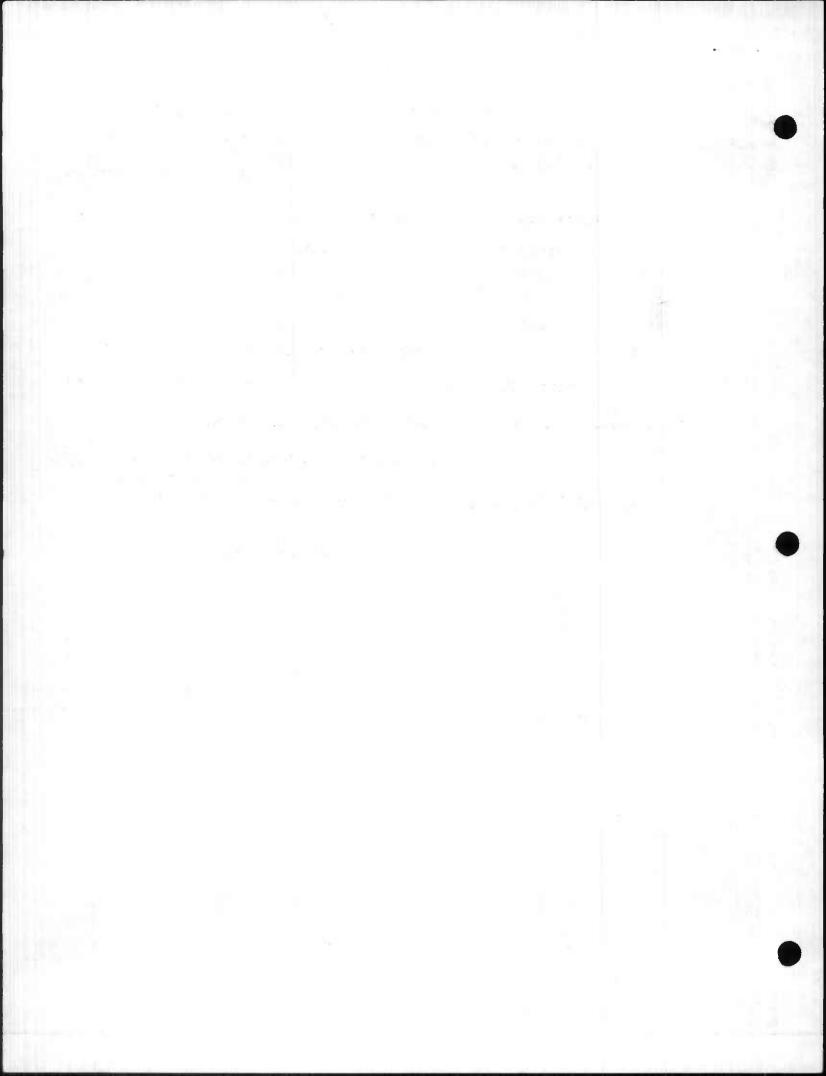
29c. License number D47924 29d. Date signed (Month, Day, Year)

30. Name end address of person who completed cause of death (Item 23e) (Type, Print) NOMAN THANKY 10 AURORA ST.

31. Date filed (Month, Dey, Year)

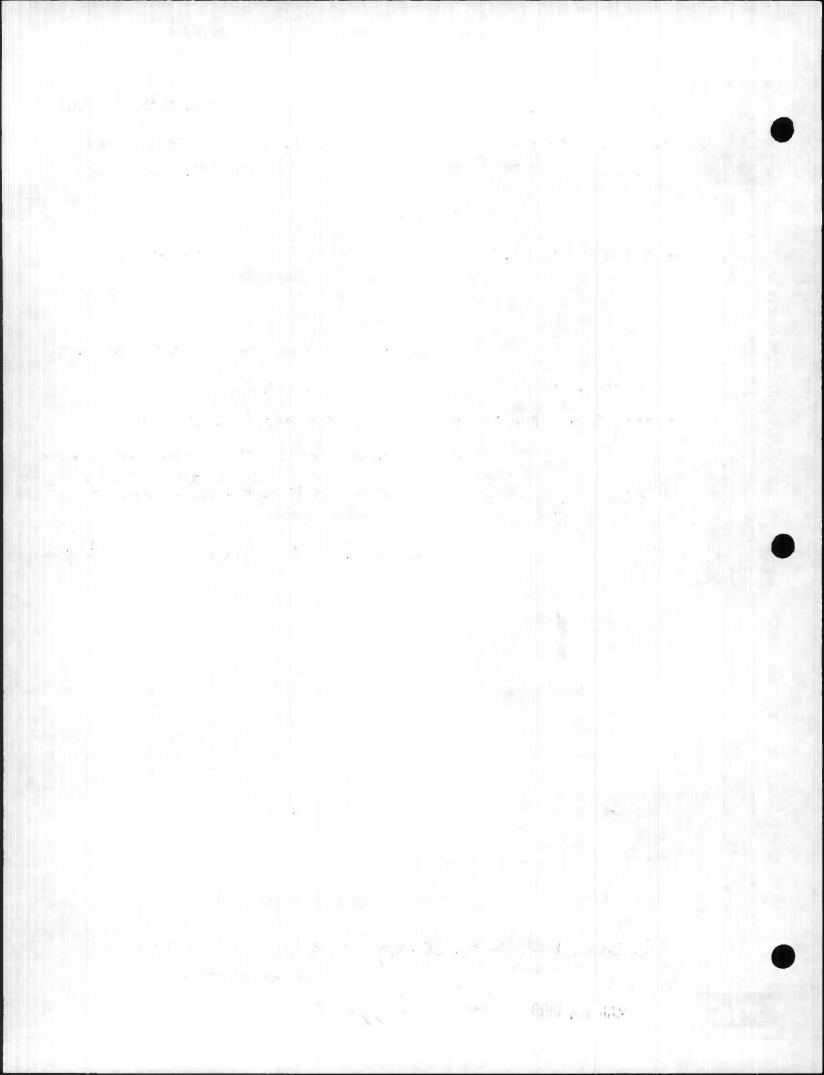
32. Registrar's Signature MAR 0 8 1999

State Registrar



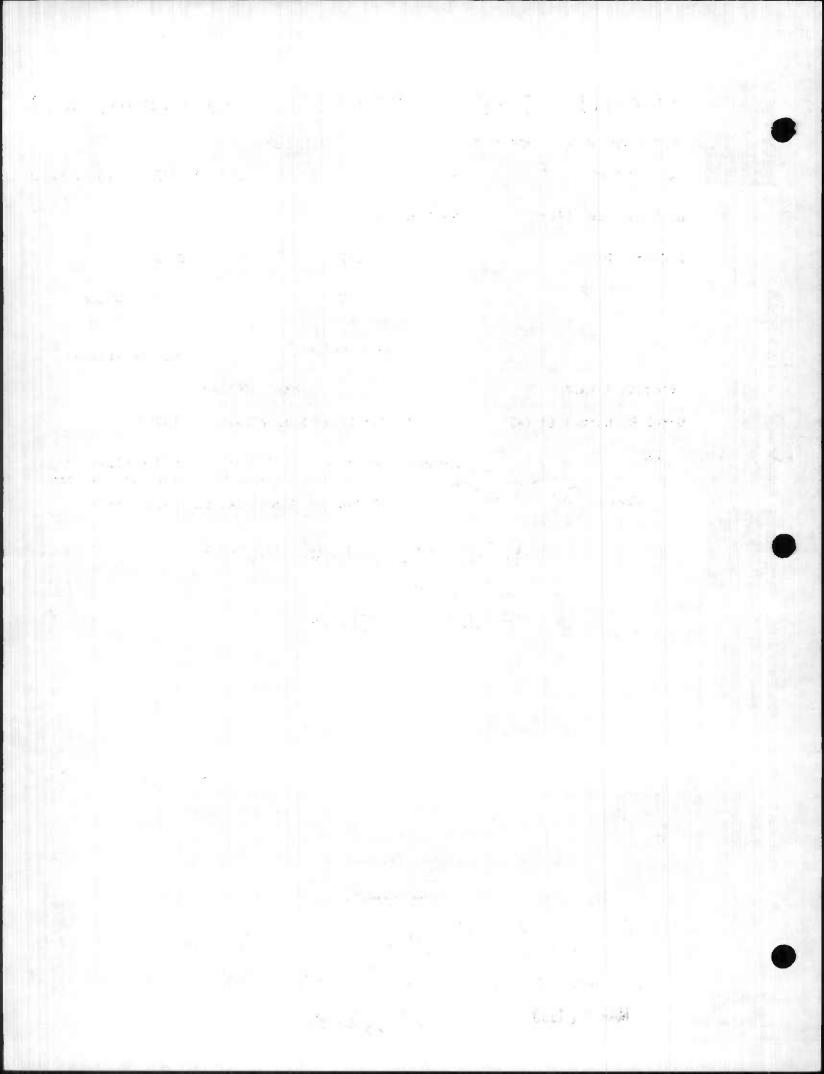
State of Maryland / Department of Health and Mental Hygiene

				Otato o	· Waryia		rtificate o	f Death	vicinairiy	Reg. No.		8851	
B	Physicia	_	1. Decedent'a Name (First, Middle					13	2. Date of De	Day	Yeer	3. Time of Death	
	/Medica	ıl -	Ann Chappe		m <i>her</i>)			4b. City, Town, or U			of Death	6:00AM	
A	Examine	r	Chesapeake Hos	THE STATE OF THE S				Linthicum		Anne Arundel			
	Funeral Director		5. Social Security Number 254-58-6433			s. last birthday, Yrs.	Months Day	ar If Undar 24 Hrs.	8. Data of Bir (Month, Di Aug. 18	ay, Year) 3,1933		placa (State or Foreign	
	Maryland f ehow		Usual Residence of Decedent 10a. State 10b. County			city, Town or Lo	ocation on, D.C.			10d. Inside t			
	h with the	Funeral Director	10e. Street and Number 4000 Cathedral	Ave. N.W.			10f. Zip Code 200	9		10g. Citizen of What Country? United States			
020			11. Marital Status 1 Naver Married 2 Marri 3 Widowed 4 Divorced	12. Was Dece Armed For ied 1 Yes If Yes, Giv Year or Da	rce67 2 ☑ No /e		Was Decedent of If Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puart to Specify:	pecify Yes or No o Rican, atc.)	5 14. Race Blace Specify	can Indian, etc. i te		
Maryland 21215-0020	C .	Be Completed by	15. Decedent (Specify only highes Etementary/Secondary (0-12)	t grade completed) College (1	l-4or 5+)			cupetion ne during most of wor ired)		16b. Kind of Bu			
d 2	be filed within tal Hygiane. d other than event, the Man	3	17. Father's Name (First, Middle,	Last) 4		Legis	Tative A			, Maiden Surnam		IIIEIIL	
lan		0 20	John Walter Cha					Rena Bol			7		
any	2 should be and Ments Is marked eumatic e	-	19a. Informant's Name/Relations	nlp (Type, Print)		19b. Mail	ing Address (Str	eet end Number or Ru		per, City or Town,	State, Zip	Code)	
Σ,	r tr	-	Jeanne B. Pagle	e, (friend	olis, M								
Baltimore,	4 m		20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 □Removal from specify)		Linco		atory 3/4/			od, N	Varyland	
Ball	permit. Pa Departmen Important: any Injury pnce.		21. Signature of Funeral Service	Ch. E	cole			of Glouce				MD 21401	
	Physician		23a. Part1. Enter the diseese, or shock, or heert failure. List	complications that conly one ceuse on e	aused the dea ech tine.	ath. Do not en	iter the mode of	tying, such as cardiac	or respiratory a	arrest,		Approximate Intervet Between Onsat and Death	
ă	/wedicar Examiner	1	tmmediate Cause (Final disaasa or condition resulting in death)	θ		Br	aly	Cai	nier			tyear	
		E	Todamiy III doubly		Due to	(or as a conse	quenca of):						
	and transit	Examiner	Sequentially list conditions,	b	Dua to	(or as a conse	quance of):				T		
68760,	ata be hysicia the bu	Car	Sequentially list conditions, if eny, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Dua to ((or as a consec	quanca of):						
	* D 6	_		d									
. Box	death cert e attendin ed for use	Cla	Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Pert I.							23b. Did tobacco use contribute to the cause of			
s, P.O.	requires that the death cert een signed by the attendin hould be datached for use	by Physicianim				•				Yee 2 No		bably 4 Unknown	
Division of Vital Records,	2000	Completed								s an autopsy ormed?	av	ere autopay findings railable prior to empletion of cause death?	
œ =	The late he page								10	Yes 2 No	1 [☐ Yes 2☐ No	
Vita	clan: ector,	0	25. Was case referred to medical axaminer?	Hospital:				26. Place of Dea					
ou of	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	10011	1 Yes 2 No 27. Manner of Death 1 Naturel 5 Pendin 2 Accident investig	28a. Date of		28b. Time of Injury	of 28c. In	4 ∠ Nursing H njury at Vork?		idenca 6 Other		ý)	
Divisi	To the Hospital or Attending f within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Cermication	2 Accident Investig 3 Suicida 6 Could r 4 Homicide determ	ot be 28e. Place	M 1 Yes 2 No					(Street and Numb own, State)	er or Rur	al Route Number,	
	Hospita 24 hours Funeral letely filled	Medical	29e. Certifier 1 Certifyin (Check only one) 2 Medical I	Examiner: On the ba	best of my kn asis of exemin	nowledge, deat netion and/or Ir	th occurred at the ovestigation, in m	time, date end plece y opinion, death occu	, and due to the rred at the time	cause(s) end ma , dete end piece,	nner as s and due to	tated. the cause(s)	
	within To the	B	29b. Signeyore and title of certifier		4	A	29c. Lic	ense number		29d. Date signer	d (Month,	Day, Year)	
		De June J Maliny D22028								March 2, 1999			
			30. Name and address of person Paul Scott Rhoo	who completed caus des, M.D.	of death (Ite	om 23a) (Type Crofton	Centre	, Crofton,	MD 211	14			
	State Registra	•	31. Date filed (Month, Day, Year) MAR 0 4	1999	egistrar's Sigr	gature 4.	Spour	to					



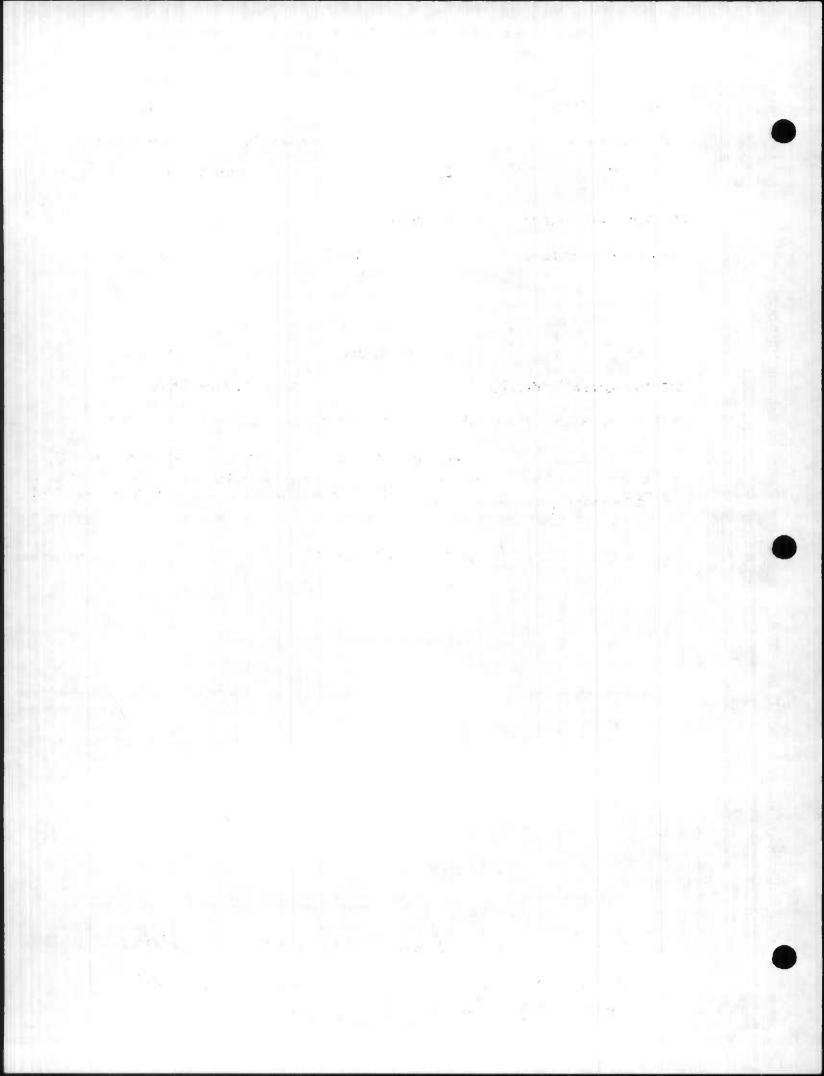
State of Maryland / Department of Health and Mental Hygiene 9

Physician /Medical Examiner	Certificate of Death	Reg. No.		
	4 City Tour or location of the	2 UARY 23, 1999 16	of Death	
Funeral Director	THE JOHNS HOPKINS HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) When the property of the proper	X.		
natural, or items 23s or 28s-f show diesi Examiner must be notified at eted by Funeral Director	10a. State 10b. County 10c. City, Town or Location	10d. Inside	City Limit	
to roto	West Va. Hampshire Springfield	1 🗆 Yes 2 🗖		
or 28a-1 s by notified Director	10e. Street and Number 10f. Zip Code	10g. Citizen of Whet Country?		
23a		U.S.A.		
if hearing and Merclad hygiene in the first of theme 23e or 28e-f show other traumatic event, the Medical Examination to the notified at TO Be Completed by Funeral Director	11. Meritel Status 12. Was Decedent Ever in U,S. Armed Forces? 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Wes Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 15. Wildowed 4 Divorced 16. Was Decedent Ever in U,S. Armed Forces? 17. Yes 2 No Specify: 18. Wes Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Raca - American Indian, Black, White, etc. Specify: White		
ed t		18b. Kind of Business/Industry		
ygiene. her than "naturallit, ihr Wedicalli Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+)			
Com	8 Self Employed	Transportation		
d oth event	17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle)	dle, Malden Surname)		
and Mental Hygiene. s marked other than sumatic event, the M To Be Comp	Florris Raines Mamie Fuller			
re al	19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number of Rural Route Numbe			
item 27	Carol W. Raimes (wife) 1 Ceader Drive Springfield, 20a. Method of Disposition 20b. Plece of Disposition (Name of Date	20c. Location - City or Town, State		
0	1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other placa)			
important: if	4 Donation 5 □ Other (Specify) Lakemont Cemetery 2/27/99 21. Signature of Funeral Service Ucens 22. Name end Address of Facility John M	Davidsonville, M		
Department Important: If any Injury o once.	Benedych Balen 147 Duke of Gloucester A	nnapolis, MD 2140	1	
	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line.	y arrest, Approxim Intervel E Onset an	Between	
ysician Aedical aminer	Immediate Cause (Final disease or condition resulting in death) a. PERIPHERAL VASCULAR DISEASE Due to (or es a consequence of):	E 10 YEA	HRS	
in sit	SEPTICEMIA	2 DA	YS	
ise es the burial-transit		2 DA	45	
es been signed by the attending physic 2 should be deteched for use as the 1 holes by Should be by Physician/Medica	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. D	old tobacco use contribute to the caus	e of dea	
should should		fas an autopsy aroimed? 24b. Were autops aveilable pric completion of death?	or to	
		Yes 2 No 1 Yes 2	SNO.	
page 2	25. Was case referred to medical axaminer? 28. Place of Death (Check on examiner)	ly one)		
ertificate he ector, page Be Com	1 Yes 2 No Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 R	esidence 6 Other (Specify)		
is certific director		be how injury occurred		
After this certific funeral director, tion: To Be	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No			
effer death. Director: After this certification by the funeral director. ertification: To Be	28d. Date of Injury 1 Description 2 Accident investigation 3 Suicide 4 Homicide Homicide Homicide Location 28d. Date of Injury 28d. Time of Injury (Month, Day Year) (Month, Day Year) 28d. Time of Injury (Month, Day	n (Street and Number or Rural Route N Town, State)	u <i>mber</i> ,	
effer death. Director: After this certification: To Beertification: To Be	1 Natural 2 Accident 3 Suicide 4 Homicide 4 Homi	Town, State) he cause(s) and manner as stated.		
effer death. Director: After this certifict in by the funeral director. ertification: To Be	1 Natural 2 Accident 3 Suicide 4 Homicide 4 Homi	Town, State) the cause(s) and manner as stated. ne, date and pleca, and due to the caus 29d. Date signed (Month, Dey, Year	e(s)	
h. After this certific funeral director, tion: To Be	1 Natural 2 Accident 3 Suicide 4 Homicide 4 Homi	Town, State) he cause(s) and manner as stated. he, date and pleca, and due to the caus	e(s)	



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Dey}1999 **Physician** Feb. Dorothy R. Rakow 28 6:10PM /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Road 266 Providence Anne Arundel Annapolis 8. Dete of Birth (Month, Day, Year) Feb. 12, 1917 If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys 1 M 2 F Months Hours 244-72-8426 82 Yrs. Washington, D.C **Director** Usuei Residenca of Decedent 10d. Inside City Limits the Maryland r 28a-f ahow a notified at 10s. Stete 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Maryland Anne Arundel Annapolis Directo 10e. Street end Number 10f. Zip Code 10g, Citizen of Whet Country? with 9 7 is marked other than "naturel", or items 23s or traumatic event, the Medical Examiner must be r 21401 United States 266 Providence Road death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Deles: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien. 11. Meritel Status Bleck, White, etc. permit. Peges 1 and 2 should be filed within 72 hours efter Department of Health end Mental Hygiene. Important: if item 27 is marked other than "naturel", or ita any injury or other traumatic event, the Medical Examena. 1 Never Merried 2 Married Specify: White 1 Yes ZNo altimore, Maryland 21215-0020 Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Thomas Nelson Ransdell Amparo Martin-Rivero 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 266 Providence Road, Annapolis, MD 21401 William N. Rakow, Jr. (son) 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition
1 ☑ Burial 2 ☑ Cremetion 3 ☑ Removel from State 20c. Location - City or Town, State Arlington National 3/10/99 Arlington, Virginia 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Pert1. Enter the disease, or complications thel caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate interval Between Onset end Deeth Physician Immediate Cause (Finel disease or condition resulting in death) /Medical 3 months **Examiner** or es e consequence of) Examiner physician and s the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or es e consequença of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): ettending pt signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Were eutopsy findings eveilable prior to should b 24e. Wes en eutopsy performed? Completed completion of cause of death? certificate hes b lirector, page 2 s 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) 5 Residence 6 Other (Specify) To. 1 Yes 2 No Hospitai: Other: 4 Nursing Home 1 Inpalient 2 ER/Outpetient 3 DOA this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 1 Naturei 2 Accident 5 Pending 1 Yes 2 No To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At completely filled in by the fu deeth. Investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred at the time, dete and plece, end due to the cause(s) end menner stated. 29a. Certifier edical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier ellnere Welling, m1) 00052830 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Jeanine Wenner M.D. 900 Bestgate Road , Suite 300 Annapolis. 31. Date filed (Month, Day, Year)
MAR 0 2 1999 32. Registrar's Signeture State Registrar



State of Maryland / Department of Health and Mental Hygiene 99 08854

hysician	1. Decedent's Name (First, Middle, I		777					2. Dete of Dec Month March		Year	3. Time of Deeth	
Medical	DONALD	RUS								1999	8:30 PM	
caminer	4e Fecility Name (If not institution, g		per)					cation of Deeth				
	Heartland Nursi		A //-	to a biabata si	If Under 1 Ye	Hyat			Prince			
neral ector	5. Social Security Number 246-22-7955 Usual Residence of Decedent	Sex 7. 1 ☑ M 2 ☐ F	72	. last birthday) Yrs.	Months Day		Min.	8. Dete of Birt (Month, Da) 07/26/	y, Year) 1926		ace (State or Fore	
A notified at Director	10a. State 10b. County		10c. Ci	ity, Town or Loc	ation				10	d. Inside City Limi		
tor	DC N/A		Wa	Washington								
je je	10e. Street and Number				10f. Zip Code)		10g. Citizen of What			ry?	
al	111 Quackenbas S	treet, NW	J	20011					USA			
by Funeral Director	11. Maritel Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Deceded Armed Force 1 Tyes 2 If Yes, Give	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes X No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Orl If Yes, specify Cuban, Mexicar 1 ☐ Yes 2 ☐ No Specify:					ecify Yes or No- Rican, etc.)		ick, Whita, e	American Indien, Whita, etc.	
8	15. Decedent's	Education		16e. Decedant's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)					16b. Kind of B	Business/Ind	ustry	
Be Completed	(Specify only highest g Elemantary/Secondary (0-12)	college (1-4	lor 5+)	life. D	kind of work do: OO NOT use rel	ne dunng mosi ired)	t of worki	ng				
Con		2		Contractor					Self Er	nploye	d	
Be (17. Fether's Name (First, Middle, La	st)		18. Mother's Name					Maiden Sumai	me)		
10	James C. Rush			Greta Board 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, St.								
	19a. Informant's Name/Raletionship	(Type, Print)										
	Ruth C. Hanna		0.01	111 Quackenbas St. NW, 20b. Place of Disposition (Name of cemetery, cramatory or other place)					_		0011	
ment of land: If It land: If It land: If It	20a. Method of Disposition 1 Buriel 2 Cremetion 3 4 Donation 5 Othar (Special Contro		ate	tchell				wn, Slate				
	4 Donation 5 Other (Specify) Mitchell Cemetery Asheboro, 21. Signature of Further Serves Licensee 22. Name and Address of Facility Marshall's Funeral Home											
	47		on, DC	2001	1							
an	23a Bert1. Enter the disease, or co shock, or heart failura. List on	mplications that cau ly one cause on eac	used the dee th line.	th. Do not ente	or the mode of o	tying, such as	cerdiac o	or respiratory e	rrast,		Approximata Interval Between Onset and Death	
al er	Immediate Cause (Final disease or condition resulting in death) ALZHEIMER S DISEASE										Years	
	Due to (or as a consequence of):											
edical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disassa or Injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of):											
-	Causa (Disaasa or Injury that initiated events resulting in death) Last	c	Due to (d	or as a consequ	uence of):							
clan	d.									1		
by Physician/N		contributing to deat	th but not res	ut not resulting in the undarlying ceuse given in Part I.					Yes 20 No		the cause of deal	
by P	Dysphagia											
pleted	Parkinson's Dis	sease						24a. Was perfo	an autopsy rmed?	ava	ore autopsy finding illabla prior to inpletion of cause death? N/A	
Medical Certification: To Be Com								10	Yes 2X No	10	Yes 2□ No	
	25. Was cese referred to medical examiner?						of Death	n (Check only o	one)			
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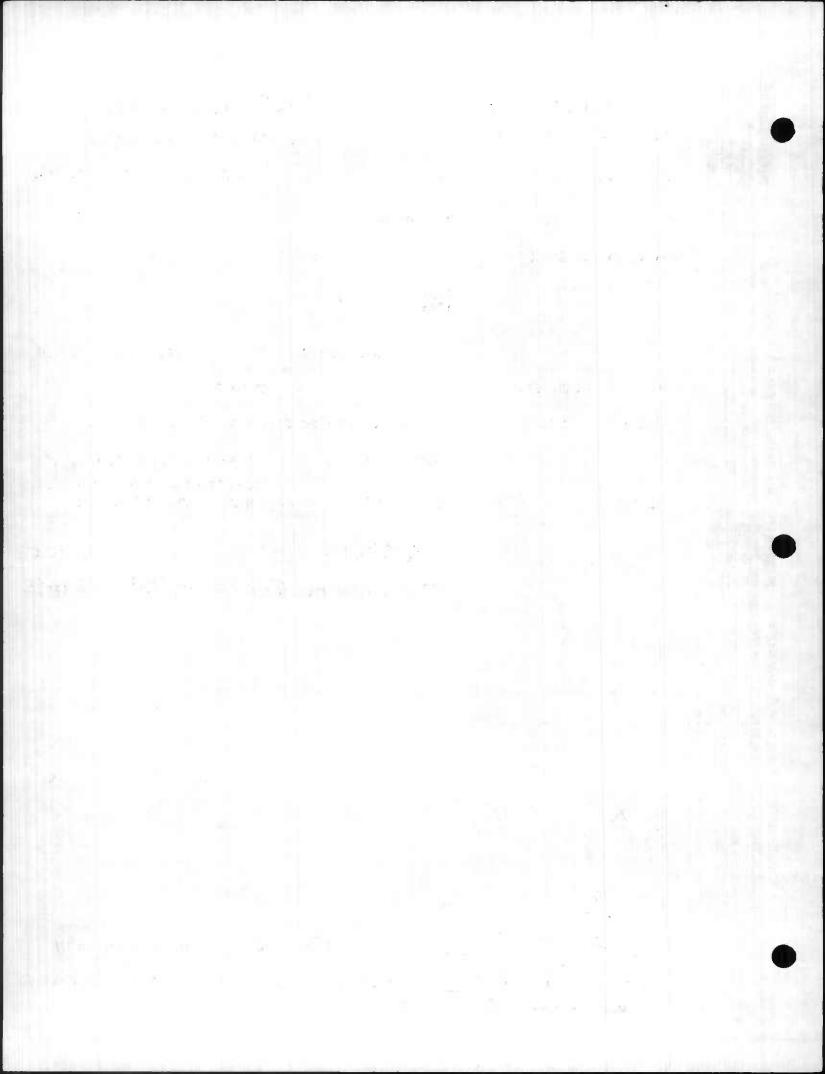
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State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3 Time of Death MARCH 4, 1999 **Physician** 10:37PM CHARLES /Medical 4a Facility Name (If not institution, give street and number)
THE JOHNS HOPKINS HOSPITAL 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** BALTIMORE CITY BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1☐M 2☐F Yrs. 52 13, 1946 WEST VIRGINIA **Director** 236-72-0521 Usual Residence of Deceden with the Merylend 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County YOS 2 No BERKELEY MARTINSBURG Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Peges 1 and 2 should be filed within 72 hours effer death with Department of Health and Mental thygiene. Important: If Item 27 is marked other than "any injury or other treument." ir than "naturel", or items 23a or 208 W. MARTIN STREET 25401 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 No If Yes, Give 1 Never Married 2 Married 1966-1 Yes 2 No Specify: à Specify. 3 ☐ Widowed 4 🗓 Divorced WHITE 1969 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) HOUSEKEEPING V.A. MEDICAL CENTER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CHARLES L. RICE, SR. THELMA MASON 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAREN RICE/SISTER 126 N. RALEIGH ST., MARTINSBURG, WV 25401 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State HARMONY CEMETERY 3-9-99 4 Donetion 5 Other (Specify) FALLING WATERS, WV 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, 21. Signature of Funeral Servica Licenses Narles 327 W. KING ST., MARTINSBURG, WV 25402 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final diseese or condition resulting in death) /Medical 3 WEEKS Examiner SOPHABEAL PERFORATION Examiner physician end the buriel-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Division of Vital Records. P.O. Box 68760. Physician/Medical Due to (or as a consequence of) 98 USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b, Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings evailable prior to completion of ceuse of death? should I Completed 24a. Was an autopsy periomed? certificate has b 1 ☐ Yes 2 No 2 No 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No

27. Mapner of Deeth
1 Natural
2 Accident Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 2 ER/Outpatient 3 DOA this funeral 28b. Time of 28d. Describe how injury occurred After or Attending 5 Pending efter death. 1 Tyes 2 No Investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end menner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai To the Hosp within 24 hor To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of couling RES-000 MARCH 4, 1999 30. Name and address of person who completed cause of death (item 23e) (Type, Print) JOHNS HOPKINS HOSPITAL, BALTIMORE, MARYLAND SINGER State

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Alice Miller ROELKE MARCH :40 Am /Medical 4c. County of Deeth 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth Examiner Washington COFFMAN NURSING HOME HAGERSTOWN If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) March 23,1907 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Months Deys Hours 1 M 28 F 91 Yrs. 212-50-8422 Director Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits -how 1 N Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 1304 Pennsylvania Avenue 21740 USA Funeral death Heme Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. Was Decedent Ever in U,S. Armed Forces? hours after 1 Never Merried 2 Merried 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 6 Maryland 21215-0020 1 Yes 2 No Specify: Specify: white à 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantery/Secondary (0-12) College (1-4or 5+) homemaker her own home 12 0 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) Be permit. Pages 1 end 2 should be Department of Health and Mental Important: If Item 27 is marked or eny Injury or other traumatic eve Clarence Heller Baker Elizabeth Logan 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) Elizabeth Mougey - daughter 3212 Dunnington Rd., Beltsville, Md. 20705 altimore. 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1₺ Buriel 2 Cremetion 3 Removel from Stete Rose Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 3-8-99 Hagerstown, Maryland 22. Name and Address of Fecility MINNICH FUNERAL HOME 21. Signeture of Funeral Service Licenses 415 E. Wilson Blvd., Hagerstown, Md. 21740 Wester 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Year. /Medical Immediate Cause (Final disease or condition resulting in deeth) **Examiner** Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Couse (Diseasa or Injury that initiated events resulting In death) Last Due to (or as e consequence of): Physician/Medical Due to (or es a consequence of) Pert tt. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Division of Vital Records. 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy completion of cause of tleath? 1 Yes 2€No certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physicien; funeral director. Be 25. Wes case raferred to medical_ 26. Place of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Dea 28a. Date of Injury (Month, Dev Year) 28d. Describe how injury occurred 28b. Time of 28c. tnjury et Work? After 1 Chaturel 5 Pending death. investigetion 1 ☐ Yes 2 ☐ No 2 Accident after death Director; 3 ☐ Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) filled in by 4 Homicida within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledga, death occurred at the time, dete end place, end due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29e. Certifier 5 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier 29c. License number 30. Neme

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Registrar

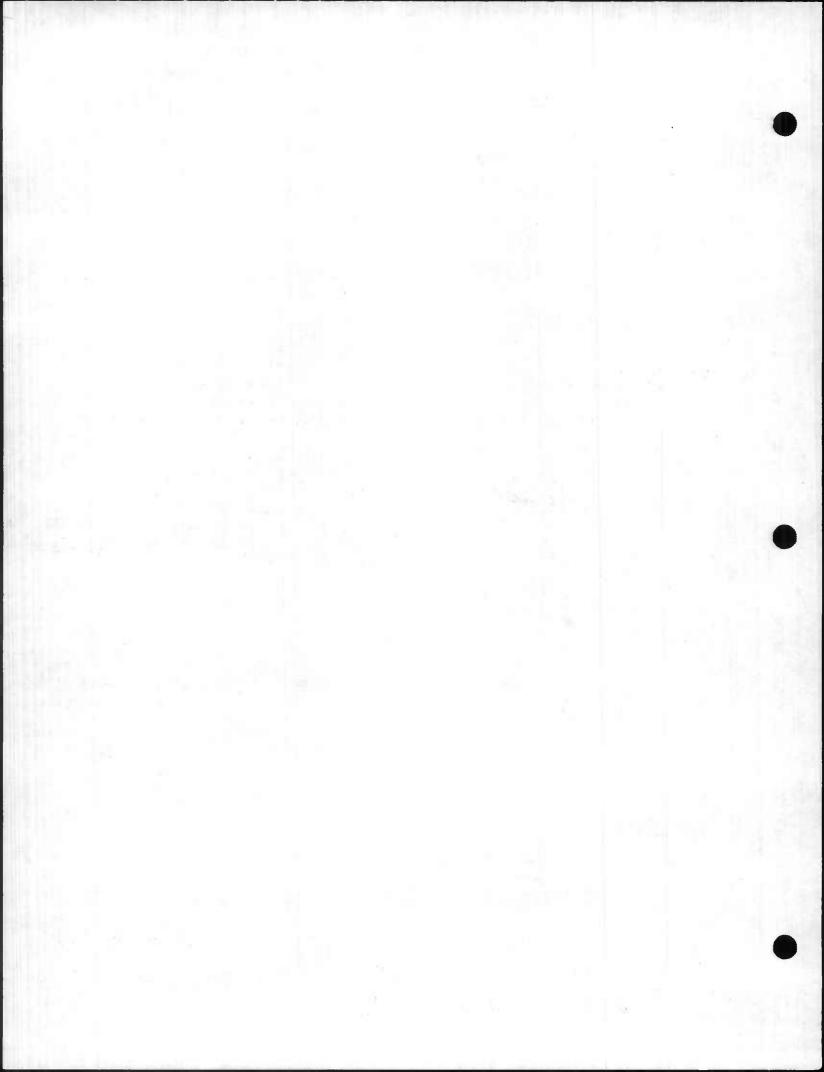
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32. Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Neme (First, Middle, Last) 2. Date of Death 3. Tima of Deeth Earl Edward Rickett, Sr. 58 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington County Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Dec. 12, 1935 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours Months 1⊠M 2□ F 63 Yrs. 218-30-9492 Maryland **Usual Residence of Decedent** 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Washington County 1 Yes 2 No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 135 McComas Street 21740 USA 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status Armed Potes. 1 XYes 2 No / 19/53 If Yes, Give 1 / 19/53 Year or Dates: 1/4/56 1 ☐ Never Married 2 Merried 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Metal Company Equipment Operator 10 0 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Robert E. Lee Rickett Edna Nyman Sheeler 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stele, Zip Code) Joanne A. Rickett/Wife 135 McComas Street, Hagerstown, Maryland 21740 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town. State 1 Burial 2 Cremation 3 Removet from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Memorial Park Mar. 11 Hagerstown, Maryland 22. Nama end Address of Facility 21. Signature of Funeral Service Licenses Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 Jaucla There 234. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart deliure. List only one cause on each line. Immediate Cause (Final 3 months Cance disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

Examiner Examiner physician and the burial-transit Physician/Medicai for use as signed by t by Completed page 2 certificate Division of Vitai or Attending Physician: 8 Certification: To this funeral After death. • Funeral Director: To the Hospital o within 24 hours af To the Funeral Di completely filled i

Physician

/Medical

Examiner

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Funeral

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"natural", or herns 23s or 25s-1 mioer must be notifi

permit. Pages 1 and 2 should be file Oppartment of Health and Meetal Hy Important: If Ilem 27 is merked oth any Injury or other traumatic event 2028.

Physician /Medical

72 hours after

filled within Hygiene.

Baltimore, Maryland 21215-0020

27. Manner of Death 5 Pending 1 Natural investigation 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, fectory, offica building, etc. (Specify) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only

29b. Signature and title of contiller

Hamdan

MAR 1 0 1999

31. Date filed (Month, Day, Year)

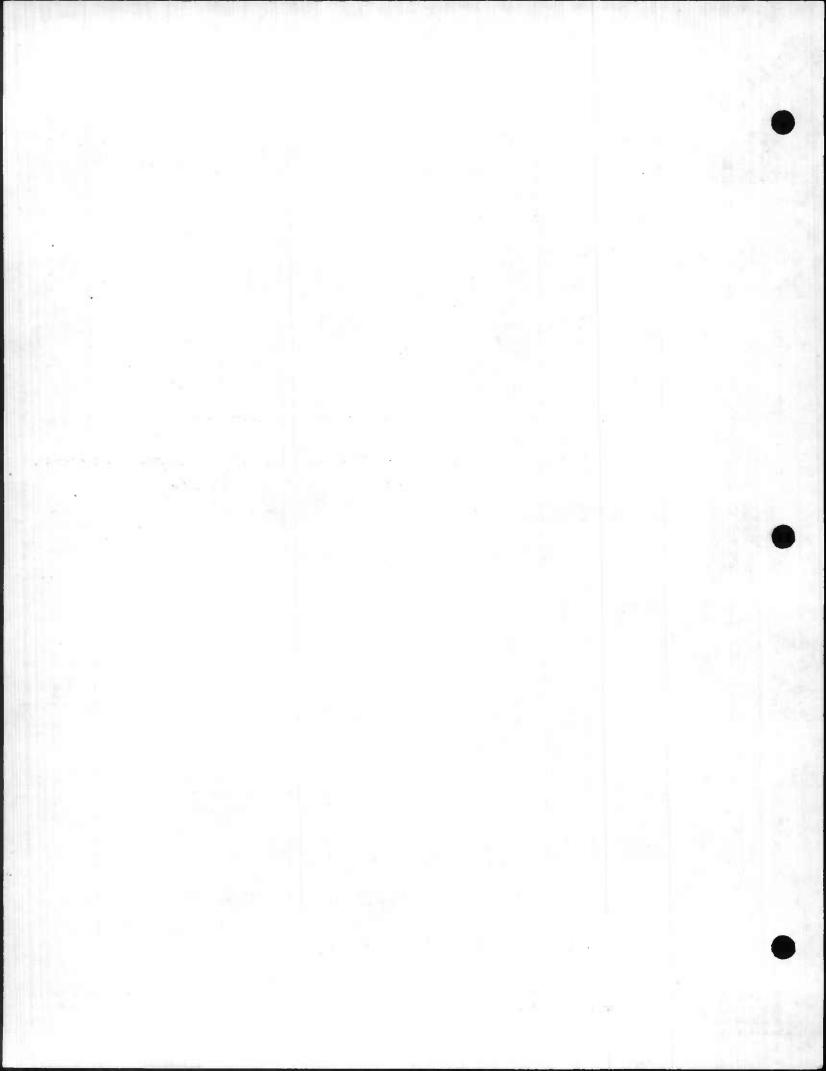
29c. License number 29d. Data signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Pript) 363 S Cleveland

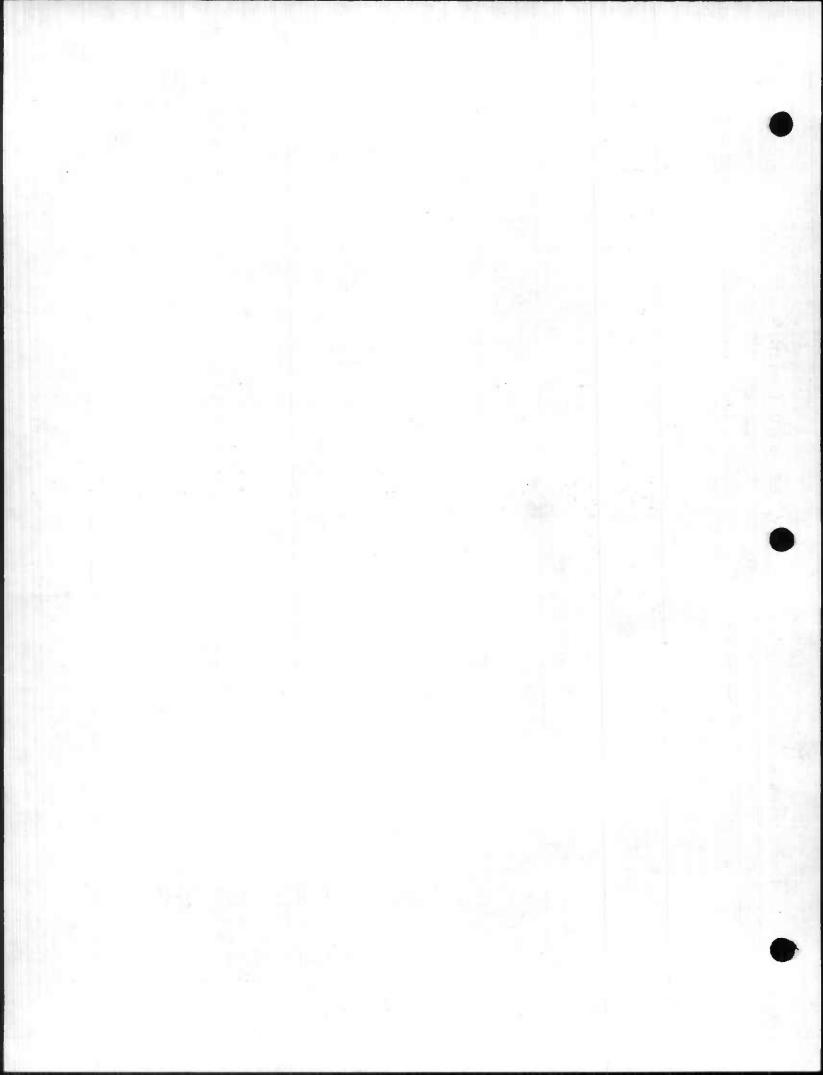
32. Registrar's Signature

State Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Rol Massen Howard 99 0=11Am 1 arch /Medical 4e Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Deeth 4c. County of Death **Examiner** Washington County Hospital Washington Hagerstown ff Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year)
Dec. 6, 1901 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 18 M 20 F 97 212-10-0047 Yrs. Director Usual Rasidance of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be nothled at 1 ☐ Yes 2 ☐No Maryland Washington Hagerstown Director 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? ò 18025 Putter Drive 21740 U.S.A. "natural", or items 23s Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: 14. Rece - American Indian, Black, White, atc. 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 72 hours after 1 Nevar Merried 2 Married Baltimore, Maryland 21215-0020 white 1 Yas 2 No Specify: Specify à 3 → Wildowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "na any injury or other traumatic event, ins Manapage. Elementary/Secondary (0-12) Collega (1-4or 5+) Supervisor 0 - 8telephone co. 18. Mother's Neme (First, Middle, Maiden Sumama) 17. Fether's Nema (First, Middla, Last) Walter Jump Roe Josephine Plummer 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a, Informent's Name/Ralationship (Type, Print) Mr. Martin L. Foltz/P.O.A. 217 East Irvin Avenue, Hagerstown, Maryland 21742 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata March 1 ⊠Buriel 2 □ Cramation 3 □ Ramoval from Stata Rose Hill Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 8, 1999 Hagerstown, Maryland Minnich Funeral Home 21. Signature of Eunaral Sary 22. Nama and Addrass of Fecility 415 East Wilson Blvd., Hagerstown, Maryland 21740 23e. Part1. Entar tha disaase, or empirculous that caused the daath. Do not entar tha mode of dying, such as cardiac or respiratory arrast, shock, or haart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** Immediata Causa (Final diseasa or condition rasulting in death) /Medical Cardio-Pulmonary Examiner Sequentially list conditions, if any, leeding to immadiata causa. Enter Underlying Cause (Disease or injury that initiated avents resulting in deeth) Last consequence of) br. Wation Physician/Medicai Due to (or es e consequance of) menmonia Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? B 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital 25. Was casa refarred to medical axaminar? Be 26. Placa of Death (Check only ona) To 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 1 Netural 2 Accident Attending 5 Pending 1 Yas 2 No Invastigation after deat Director: 3 Suicide 6 Could not be 28a. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida To the Hospital or within 24 hours after To the Funeral Di 1/2 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29e. Certifiar (Check only one) and mannar statad. 29d. Deta signed (Month, Day, Year) 29b. Signatura and titla of certifier 29c. License number 134611873 40 30. Name and address of person who completed causa of death (Itam 23a) (Type, Print) Haferstown. YANPING YU 11330 young Stous 31. Dele filed (Month, Day, Year) 32. Registrar's Signature MAR 0 9 1999 Registrar



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		Joseph F. Ruff											
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Department of Health er Important: If flem 27 is any injury or other trau		4 □ Donation 5 □ Other (Spe	cify)			Silve	r Sp:	ring, MD					
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)		30. Nama and addrass of person who completed cause of daath (Itam 23a) (Type, Print) Jenny Y Moy MD 13952 Baltimore Ave 31. Data filled (Month Day Yast) 32. Registrate Streaming								Murch	4,19	99	
/		30. Nama and addrass of person with	o complated cause		m 23a) (Type, I	Print) 3altin	iore	Ave	Laure	1 MID	207	07	
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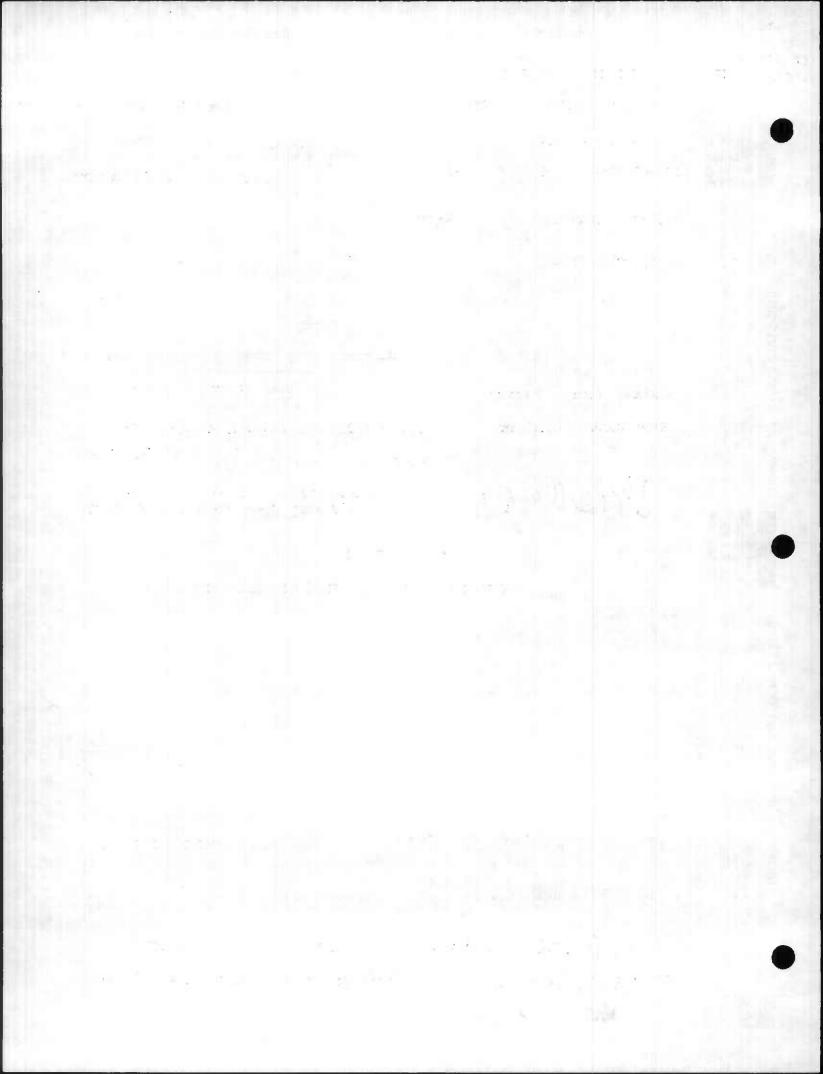
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32. Registrer's Signeture

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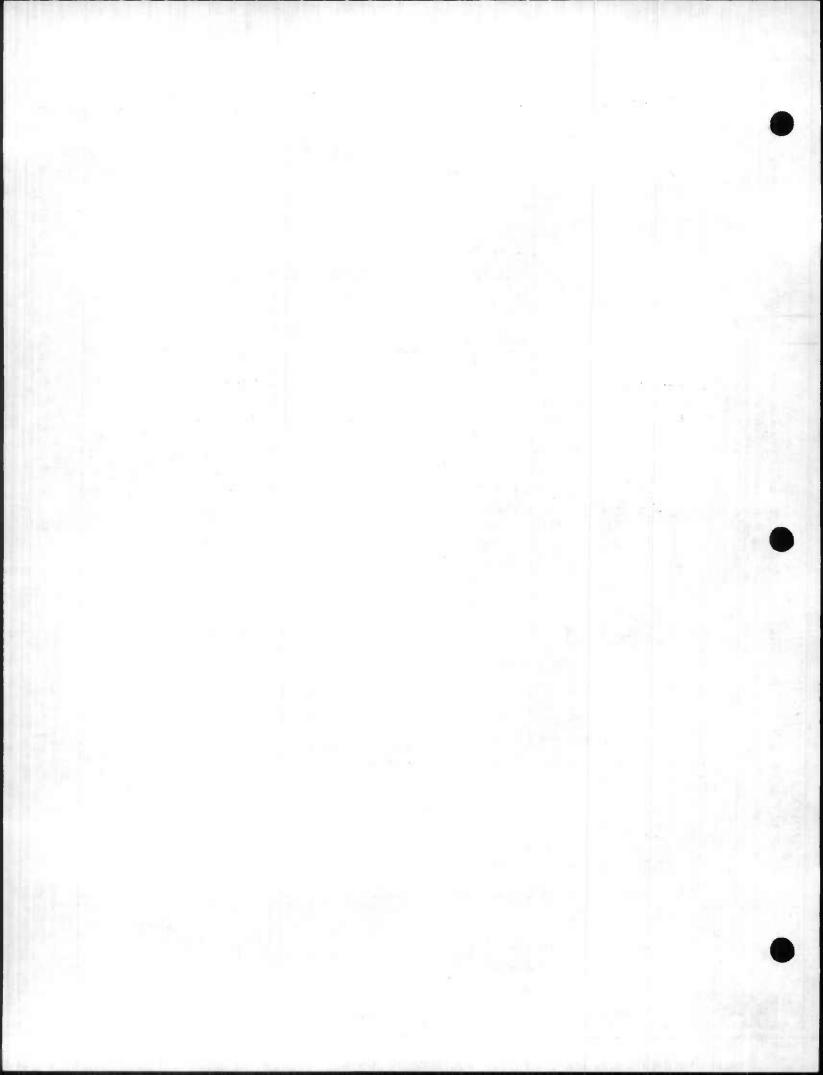
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State Registrar



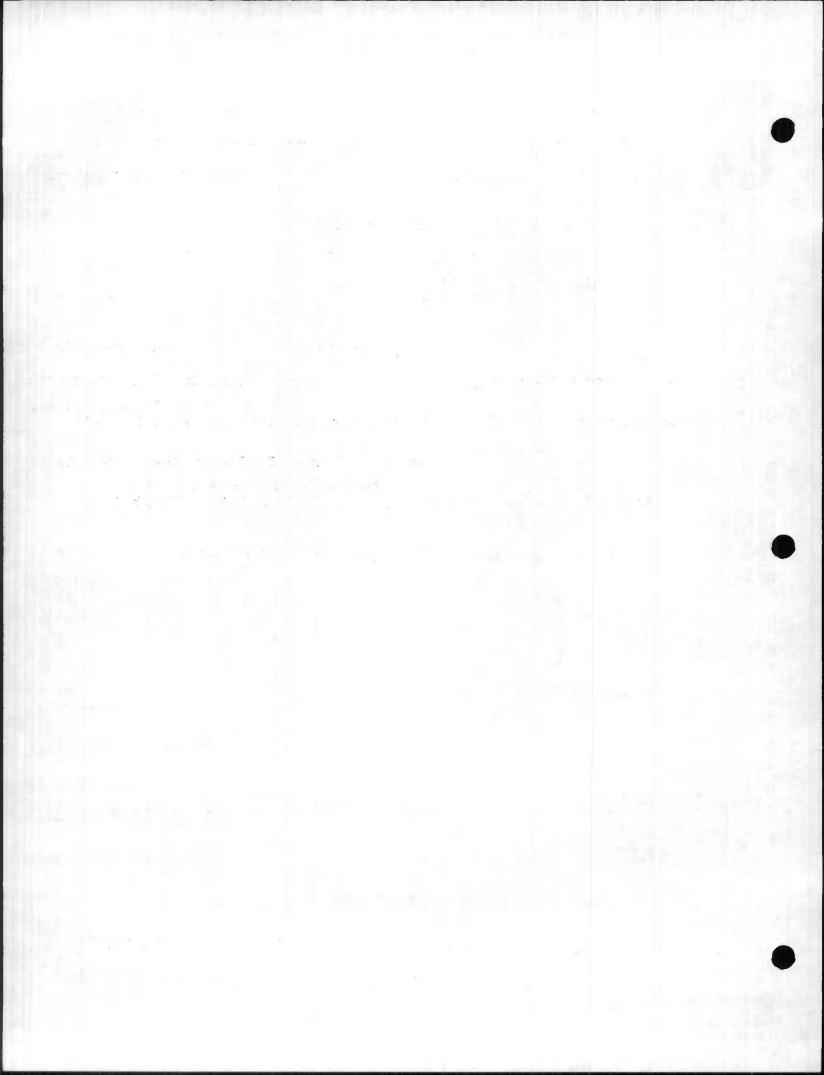
State of Maryland / Department of Health and Mental Hygiene

	Decedent's Nama (First, Middle, I	actl		Certifi	cale of	Dealli	2. Date of De	Reg. No.		3. Time of Death	
Physician	Kathryn Elizabe						Month	Day	Year	5. Time of Deali	
/Medical Examiner	4a Facility Nema (If not institution, g	ive street and number))			4b. City, Town, or L	MAR ocation of Death	h 4c. County	of Death	0100	
Examine:	Washington Coun	ty Hospita	1			Hagers	town	Was	hingt	on	
Funeral Director	5. Social Security Number 6. 209–12–5195 Usuel Rasidence of Decedant	Sex 7. Ag	ga (In yrs. lasi 87		Inder 1 Yaar nths Days		8. Data of Bir (Month, Da July 2	th ey, Year) 6, 1911		iace (State or Fore try) nsylvani	
Nend Mend	10a. Stata 10b. County		10c. City, T	own or Location	n				1	0d. Inside City Lim	
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death with the Maryland ms 23a or 28a-f show mmt be notified at neral Director	10e. Street and Number			10	of. Zip Code			10g. Citizen of	What Coun	itry?	
ath w	55 E. Washingto					740		US			
be filed within 72 hours after death with the Maryle lei Hygiere. d other than "naturel", or hems 23a or 28a-f ahon avent, the Medical Examiner must be notified as event, the Medical Examiner must be notified as been also be completed by Funeral Director	11. Marital Status 1 Nevar Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedant Armed Forcas? 1 Yas 2 If Yas, Giva Yaer or Datas:	12. Wes Decedant Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaer or Datas:		13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puarto f 1 ☐ Yas 2 ☒ No Specify:			pecify Yes or No- Plican, etc.) 14. Race - Black, Specify:		American Indian, White, etc.	
72 harmonette	15. Decedant's (Specify only highest of	Education prada complated)	1	6a. Decedant's	Usual Occu	pation during most of work	ina	16b. Kind of B	usiness/Inc	dustry	
mpi	Elamantery/Secondary (0-12)	College (1-4or	e (1-4or 5+) life. DO NOT use retired)								
Hygie Hygie of the tr	17. Father's Nama (First, Middle, La	0		homema	ker	18. Mother's Nem	a /Firet Middle		own h	ome	
ontiel on one of	John Bowman	sty .					llen Lo		ra,		
Marke marke	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing Ad	drass (Stree				State, Zio	Code)	
permit. Pages 1 and 2 should be filed within Department of Health and Mentel Hygiene. Important: if item 27 is marked other than part injury or other traumatic event, the Monte. To Be Comp	Pat Maiers - nie				g Addrass (Street and Number or Rural Routa Number, City or Town, State 3 Box $235B$, Bedford, Pa. 15522						
item item othe	20a. Mathod of Disposition		com	e of Disposition atary, cramator	(Nama of	ice)	Data	20c. Location	City or To	wn, Stata	
Page nent mr: If iry or	1 Burial 2 Cramation 3 4 Donation 5 Othar (Spec						5-99	Hagerst	own.	Maryland	
permit. Departri Importa eny Inju	4 Donation 5 Other (Specify) Rose Hill Cemetery 3-5-99 Hagerstown 21. Signatura of Funeral-Barvice Licensee 22 Name and Address of Facility MINNICH FUNERAL HOM									<i>J</i>	
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/Medical Examiner	Immedieta Causa (Final disaasa or condition		Rec	a s	eni					(45	
241	resulting in death)	· -	Dua to (or as	s a consequenc	e of):				1		
oxecuted in end rei-transit Examiner		b							1		
n end ei-tra	Sequantially list conditions, if any, laading to immediate		Dua to (or as	s a consequanc	e of):				i		
physician and is the buriel-transit edical Examir	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	Due to for es	e consequance	a of):						
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eath certif attending for use a		d			-				1		
the att thed fo thed fo	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did to								acco use contribute to the cause of dea		
ed by the detached	1.17							Yes 2□ No	3 Prol	bably 4 - Union	
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been s should leted	Aline Ebuill	eti Die	115	millie	7		24a. Was	an eutopsy omed?	24b. We	ere autopsy finding ailable prior to mpletion of cause	
The law requiras that the death cent that has been signed by the attendin page 2 should be detached for use completed by Physician/N	Caserting He	ar Fai	xun	men	12				of	death?	
Cata Cata							10	Yas 2 No	10]Yas 2□ No	
ystclen: The list is certificate he director, page	25. Was case referred to medicat axaminar? Hospital: Legation 25 No. Other: Death (Check only one)										
2 2 2	1 ☐ Yes 2 ☐ No 27. Menner of Death	1 Inpatio	ant 2 TER		J OOA J	4 LI Nursing no		dance 6 Oth		y)	
ding in.	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident invastigati	(Month, Da	28a. Date of Injury 28b. Tima of 1 28c. Injury at 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					28d. Describe how injury occurred			
tal or Attending P rs after death. al Director: After t ted in by the funers Certification:	3 ☐ Suicide 6 ☐ Could not	be 28a. Place of Inj	jury - At homa	, farm, street, f	actory, office				er or Rura	I Routa Number,	
-25- 4	4 Homicide	building, at	tc. (Specify)				City or To	wn, State)			
Hospi 14 hour Funer tely fil	29a. Certifier 1 Certifying F (Check only one)	Physician: To the best aminer: On the basis o and mannar st	f axamination	dga, deeth occu and/or invastig	etion, in my	ma, data and place, opinion, deeth occur	and dua to the red at the time,	cause(s) and madate and place,	anner as at	tated. the cause(s)	
within 2 comple	29b. Signatura end titla of certifier				29c. Licen	se number		29d. Date signe			
	- (3a	amp			DI	8019		MARCH	3, 19	175	
	30. Name and addrass of person who	complated causa of c	death (Item 23	(Type, Print)							
	n n ++	00.1	111	11	41.	1./					
	Dr. Datta	334 M	ull x	e.	Hug.	md.					



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 0 8 8 6 2

				Certifi	cate of	Death		Reg. No.	165		
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or eff.	1 Navar Marriad 2 Married 3 Widowed 4 Divorced	1 Yas 2 1	1969		Yas 21 No	Specify:		Specify	White		
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s 1 and f Health tem 27 other tr	20a. Method of Disposition	20,7 11 = 0	20b. Place	a of Disposition	n (Nema of		Data	1	City or Town, Sta	ita	
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State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Julia M. Smith 1999 March 7:00AM /Medical 4a. Facility Name (If not institution, giva street and numbar) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner CHARLES COUNTY NURSING & REHAB. CENTER LA PLATA CHARLES 5. Sociei Security Numbar 7. Age (In yrs. last birthday) If Under 1 Yaar If Undar 24 Hrs. 8. Deta of Birth (Month, Day, Yee MAY 30, 1 Birthpleca (State or Foraign Country) **Funeral** 1 M at XF Hours Yrs. 83 MARYLAND Director 578-03-4847 1915 Usual Residence of Dacadent the Marylend 10e Stete 10b. County 10c. City, Town or Location d 2 should be filed within 72 hours efter death with the Manylen th and Mental hygiene.
I the marked other than "neturel", or items 23s or 28s-f show traumstic event, the Medical Examine manthe notified at 10d. Inside City Limits 1 Yes 2 No Director MARYLAND CHARLES HUGHESVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 17050 PRINCE FREDERICK ROAD 20637 UNITED STATES Funerai 12. Wes Decedent Evar in U,S. Armad Forces? 1 ☐ Yes ②ZNo If Yas, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexicen, Puerto Rican, atc.) 14. Raca - Amarican Indian, Biack, White, etc. 1 ☐ Naver Merriad 2 ☐ Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: by Specify: 3 N Widowed 4 Divorcad WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry US NEWS AND WORLD Elementery/Secondery (0-12) College (1-4or 5+) ADMINISTRATIVE ASSISTANT REPORT permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked oths any injury or other traumatic event. 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Nema (First, Middle, Last) Be 2 EDWARD THOMAS MURPHY MARY ANN MURPHY 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) TERESA A CHAPPELEAR - NIECE 17050 PRINCE FREDERICK ROAD, HUGHESVILLE, MD 20637 20e. Method of Disposition 20b. Plece of Disposition (Neme of cematery, crematory or other plece) Dete 20c. Location - City or Town, Stete 1 A Buriei 2 Cremetion 3 Removel from Stete 5 Other (Specify) 4 Donation PARKLAWN CEMETERY, MARCH 10, 1999, ROCKVILLE, MD 21. Signeture of Funarel Service Licensee HUNTT FUNERAL HOME, INC. MG BROHAWN M00053 P.O.BOX 156, WALDORF, MARYLAND 20604 23a. Pert1. Enter the disease, or complications that caused the daath. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failura. List only one causa on aach line. Approximata Intervel Between Onset and Death **Physician** /Medical Immediete Ceuse (Finel diseesa or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner physician end the buriel-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Box 68760. Physician/Medicai ettending p Part It. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. Records, P.O. the 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 □ Probably 4 □ Unknown þ 24b. Were autopsy findings aveilable prior to completion of causa of death? Completed 24e. Wes an eutopsy Deen 1 ☐ Yes 2 X No certificate 1 ☐ Yes 2 ☐ No. Division of Vital 25. Wes cese referred to medical exeminer? Be 28. Plece of Death (Check only one) Hospitei: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 70 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) funeral 27. Menner of Death 28b. Time of Injury Certification: 28c. Injury et Work? 28d. Describe how injury occurred After 1 Natural 2 Accident or Attending 5 Pending Investigation efter deeth. 1 Yes 2 No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ HomicIde within 24 hours eft.

To the Funeral Discompletely filled in Hospital 29a. Certifian Medical 1🗹 Certifying Phyalcian: To the best of my knowledge, deeth occurred at tha tima, date and place, and due to the cause(s) end menner es steted. (Check only one) 2 Medicat Examiner: On the basis of axaminetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the ceuse(s) end manner steted. within 2 29c. License number 29d. Data signed (Month, Day, Year) MARCH 8, 1999 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

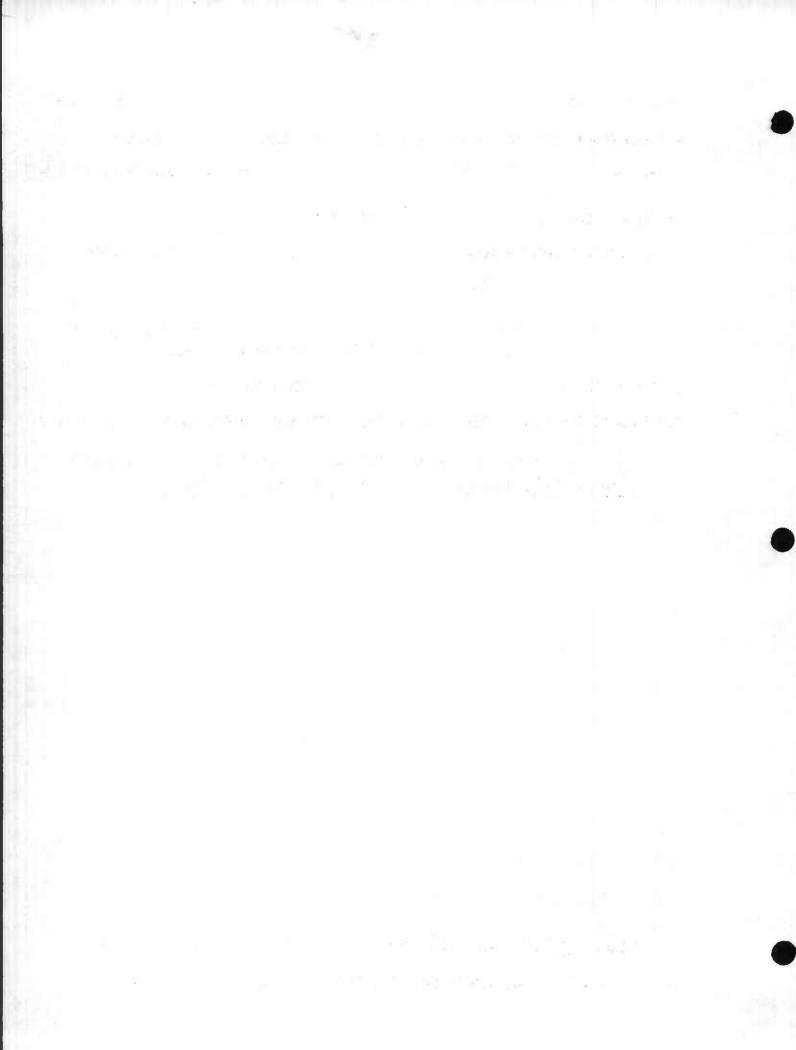
PAUL E. PRICHARD, MD., 118 LA GRANGE AVENUE, LA PLATA, MARYLAND 20646

32. Registrer's Signetura

State Registrar

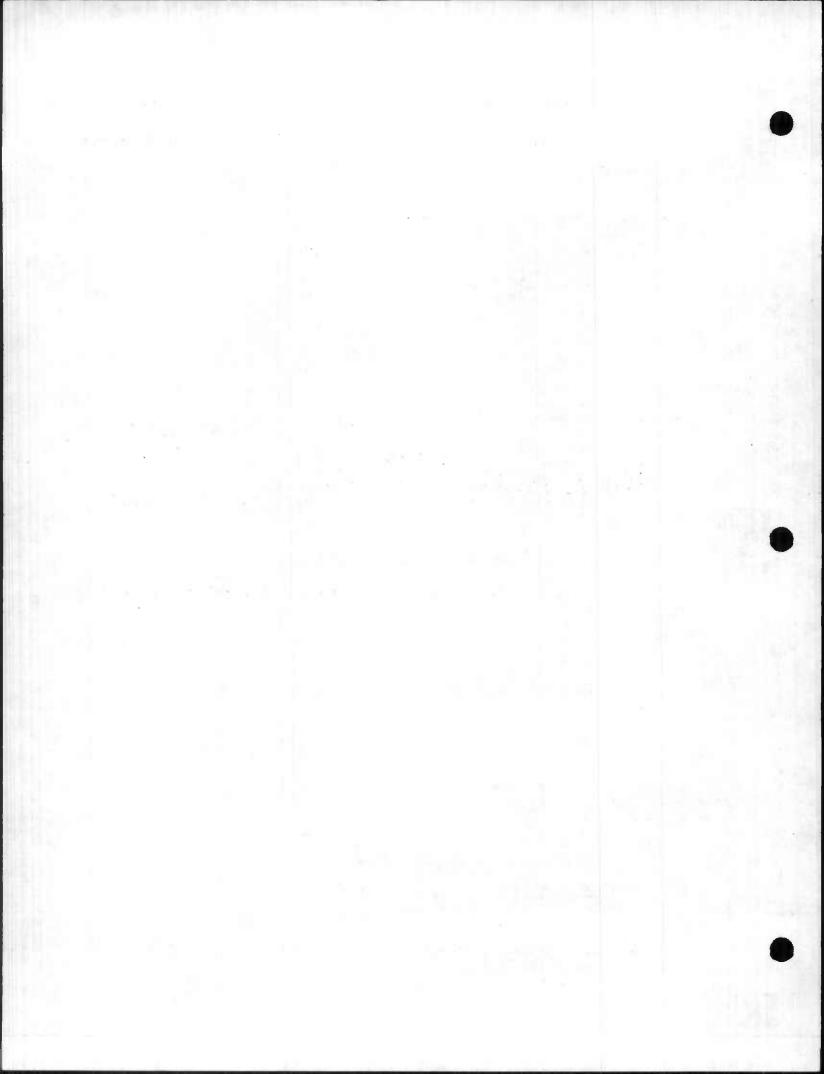
31. Date filed (Month, Dey, Year)

MAR 0 9 1999



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Cartha Chichester Seger March 4, 1999 6:30 PM /Medical 4a Facility Nama (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 8504 HEATHERWICK DRIVE BRANDYWINE PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs Hours Min. 5. Social Sacurity Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Months Days 212-34-0104 89 1910 Director Jan. Washington DC Usual Residence of Dacedent 10a State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Director Charles Maryland Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 12140 Ell Lane 20602 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Evar in U,S Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If I fem 27 is marked other than "natural". Any injury or other traumatic events. 1 ☐ Yes 2 XXIIIo It Yes, Give 1 Never Married 2 Merried 1 Yes 2XXNo Specify: White Specify: p 3XXWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Cook Restaurant 17. Fathar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Francis Grove Mary Frances Elam 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cartha D. Hall - Daughter 8504 Heatherwick Drive, Brandywine, MD 20613 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial Cremation 3 Removel from State Peter's Cemetery 3-8-99 Waldorf, MD of Funeral Service Licen 21. Signature Huntt Funeral Home, Inc. naum \$. Brohawn M0053 P. O. Box 156, Waldorf, MD 20604-0156 23a. Part1. Enter the disaasa, or complications that causad the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heef failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final . Ranal disaase or condition resulting in death) Examiner Examiner ician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events rasulting in death) Last physician Box 68760 Physician/Medicai the line Due to (or as a consequence of) P.O. 23b. Did tobecco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. been signed by the should be detach 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy tindings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? page 2 2200 1 Yes 1 TYes 2 No Division of Vital or Attending Physician: 25. Was case reterred to medicel examiner? 26. Place of Death (Check only one)
Other: 4 Nursing Home 5 A Residence daughter 6 Dother (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28a. Dete of Injury (Month, Dev Year) 28c. tnjury at Work? After 1 Neturel 2 Accident 5 Pending n 24 hours after death... Ne Funeral Director: Aft plately filled in by the ful 1 ☐ Yes 2 ☐ No invastigetion 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, term, street, tectory, office building, etc. (Specify) 4 Homicide Hospital 102 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier edicai To the Hosp within 24 hor To the Fune complately fi (Check only one) 3 29b. Signeture and title of certitie 29c. License number 29d. Date signed (Month, Day, Year) Trelporto 001923 MARCH 5, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS FIELDSON, MD, 2068 CRAIN HIGHWAY, WALDORF, MARYLAND 20601 31. Data tiled (Month, Dey, Year) 32. Registrar's Signature State Registrar 0 9 1999

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** :37 AM GROTAR /Medical 4a Facility Name (14-not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 ars. 8. Dete of Birth (Month, Day, Year) entel Anne Arunde Ame ledical 1trunde If Under 1 Yeer 5. Sociel Security Number 6. Sex 1XXM 2□ F 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Deys 84 Director 577-05-5595 Virginia Usuel Residence of Decedent with the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or flems 23a or 28a-f shov traumatic event, the Modical Examans, must be notified at 1 ☐ Yes 2 No Directo Maryland Edgewater Anne Arundel 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1619 Marlboro Road 21037 USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1XXves 2 □ No 1f Yes, Give Year or Detes: 1944–46 Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Marital Status Bleck, White, etc. permit. Peges 1 end 2 should be filed within 72 hours efter to Department of Health and Mental Hygiene. I important: If Item 27 is merked other than "natural", or flee any Injury or other traumatic event. 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: by 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 8th Plumber 1 2 2 2 2 2 2 Union Local #5 18 Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Ralph Samuel Seibert Bertha Lelia Golladay 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Linda A. Morris/ Daughter 1705 Chesapeake Drive Edgewater, Maryland 21037 20e. Method of Disposition

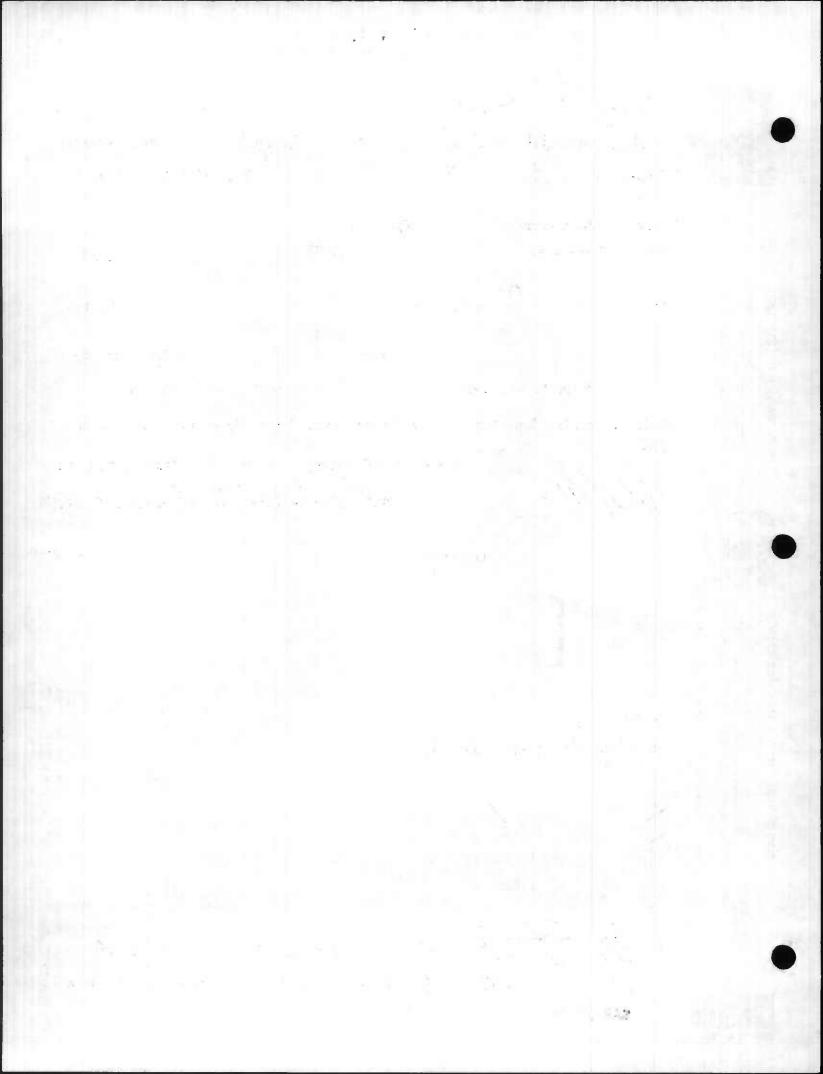
1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 20b. Pleca of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stete 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Hill Cemetery 3-5-99 Suitland, Maryland 22. Name and Address of Fecility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. art1. Enter it e disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heer failure. List only one ceuse on each line. **Physician** Immediate Cause (Finel diseese or condition resulting in deeth) /Medicai 2 days Urosepsis **Examiner** Due to (dr es e consequence of): Examiner physician end the burial-trensit that the deeth certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Lest Due to (or es e consequenca of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): 80 950 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings avelleble prior to completion of cause of deeth? Completed myeloproliferative disorder 24e. Wes en eutopsy performed? peen 1 ☐ Yes 25 No 1 ☐ Yes 2 No or Attending Physician: funerel director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours efter death. investigation 2 Accident 6 Could not be determined 3 Suicide Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end manner stated. 29a. Certifier Medical pletely (Check only one) within 2 To the 29b. Signature and Ittle of certified 29c. License number 29d. Dete signed (Month, Day, Year) MD D00532 dause of deeth (Item 23a) (Type, Print) 30. Name and address of person 972 31. Dete filed (Month, Day, Year) 32 Registrer's Signeture

DHMH 16 Rev 6/95

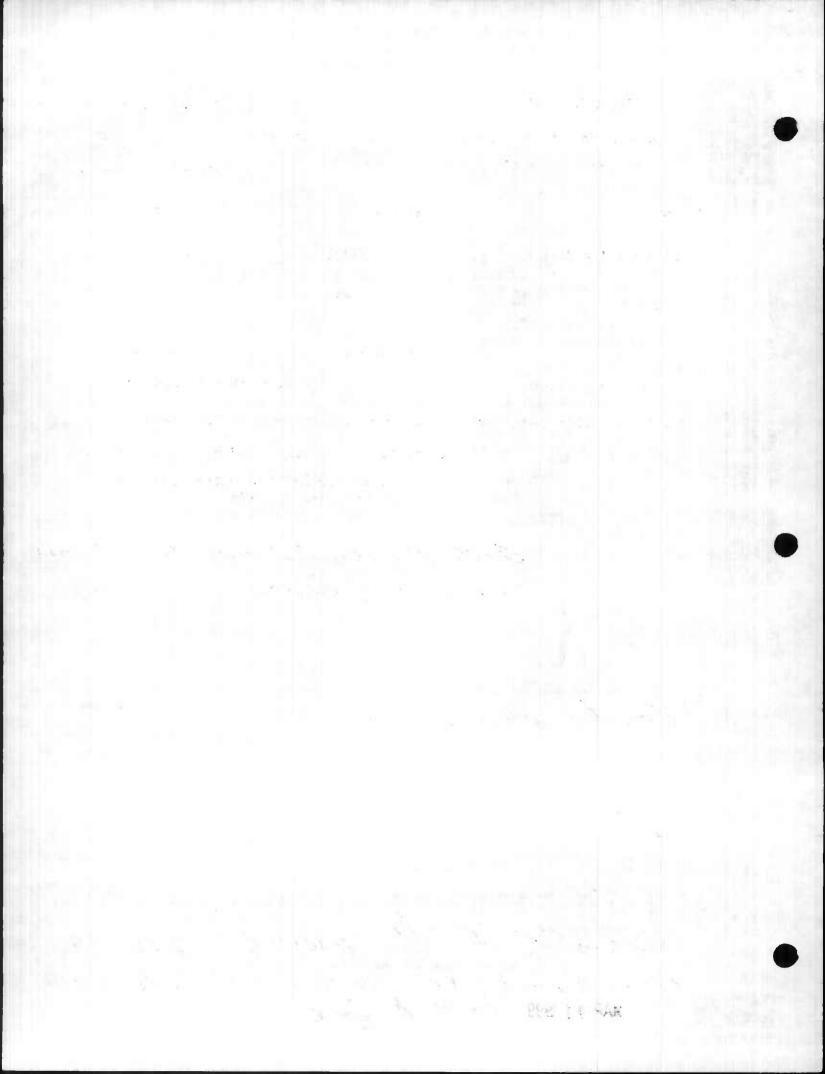
Registrar

MAR 0 5 1999



State of Maryland / Department of Health and Mental Hygiene

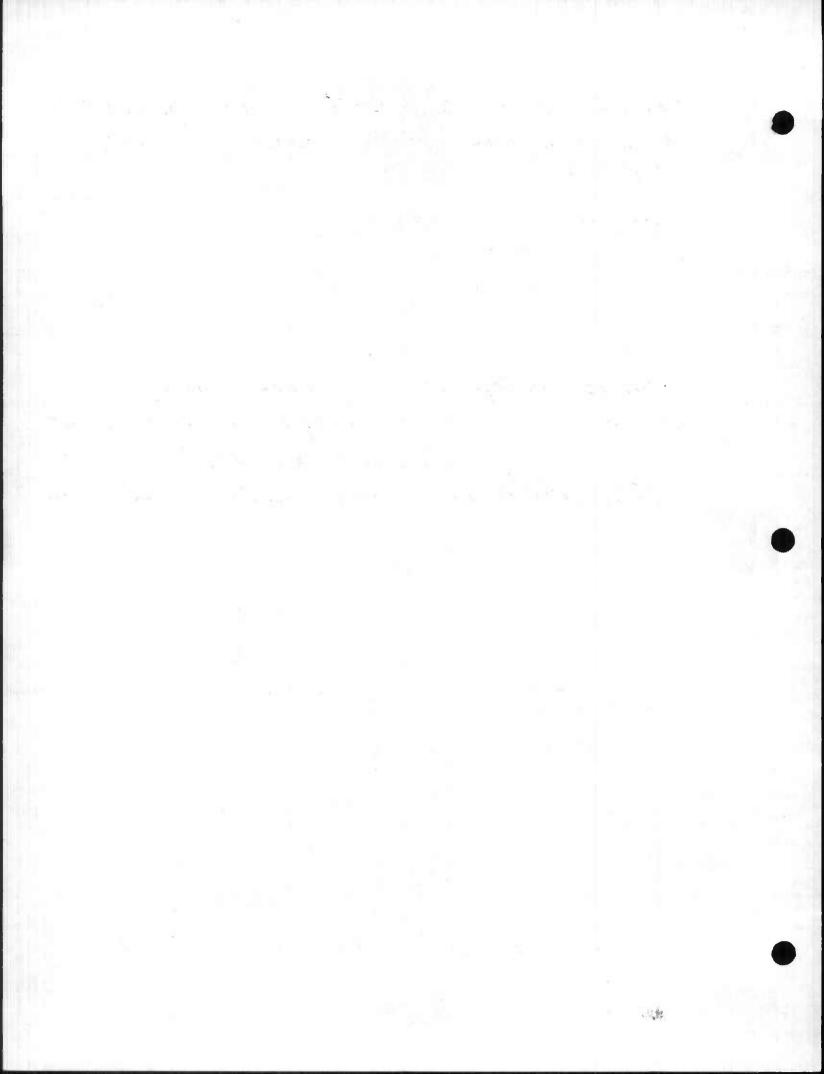
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death **Physician** ANNA MAE SPRY 26 02 1999 0715 AM · /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Frederick FREDERICK Homewood Retirement Center If Under 24 Hrs. If Under 1 Year 9. Birthplece (Stete or Foreign Country) West Virginia 8. Defe of Birth (Month, Day, Year) 06/23/12 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 M XXF 86 Vrs 203 07 3877 Director Usuel Residence of Decedent with the Marylend 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show FREDERICK XXYes 2 □ No MD Frederick Director 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 31 W Patrick Street 21701 USA Funeral death 14. Rece - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours eftar Hygiene. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married altimore, Maryland 21215-0020 White 1 Yes 2€XNo Specify: Specify: þ 3 ☐Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home i. Pages 1 and 2 should be filed vitnent of Health and Mentel Hygie tant: If Item 27 is marked other talury or other treumstic event, in 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Frank Kelly Beller Abbie Rebecca Hamilton 19a. Informant's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Box 4091/Gaithersburg MD 20885-4091 Kathleen Wolfe (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 Cremetion 3 ☐ Removel from State permit. Page Department Important: If any injury or 2/27/99 Alexandria VA Metropolitan Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22_Name and Address of Fecility Advent Funeral & Cremation Services may thoun Nagow Falls Church VA 22046 23a. Pert1. Enter the disease, or complications thet/ce/used the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause or each line. **Physician** Affection /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner artey physicien and the buriel-trans Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest P.O. Box 68760. Physician/Medicai Due to (or es e consequence of): 98 esn 0 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 2 signed be del Division of Vital Records. þ 24b. Were autopsy findings available prior fo Completed 24e. Wes en eutopsy completion of cause of death? has 1 Yes 2 12 No 1 ☐ Yes 2 ☐ No certificata or Attending Physician: 25. Wes case referred to medicel exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2□No 10 1 Inpetient 2 ER/Outpetient 3 DOA this funeral 27. Menner of Deeth 28d. Describe how injury occurred 28e. Dete of injury (Month, Day Year) 28b. Time of 28c. tnjury et Work? Certification: After 5 Pending investigation eftar daeth. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours e Hospital 1 v Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the within 2 29b. Signature and July of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) ellow 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State MAR 0 1 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Deta of Deeth **Physician** C'AROLINE REJNOLDS
4e. Facility Nama (If not institution, give street and number) Month MAICH 2030 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 7. Age (In yrs. last birthday) If Undar 1 Yaar If Under 24 Hrs. Months Days Hours Min. ROAD CECIL 1247 OLD FICLD 5. Sociei Security Number 6. Sax Birthplece (State or Foreign Country) 1□ M 2ØF 94 Yrs. 219-44-567 Usual Rasidance of Decedent December 8, 1905 Ferry man, Marylana Director the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiona. Important: if Item 27 is marked other than "natural; or Itema 23a or 28a-1 show any Injury or other traumatic event, the Medical Engineer must be not listed any Injury or other traumatic event, the Medical Engineer must be not listed as 1 ☐ Yes 2 ☑ No Director ELKTON MAGLAND CECIL 10e. Streat and Number 10f. Zip Code 10g. Citizen of What Country? ROAD 21921 1247 020 U.S. A Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) Raca - American Indien, Black, Whita, atc. 11. Meritel Stetus 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 ☐ Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: WHite é 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) College (1-4or 5+) Horse Trainer + FAIM OWNER HOISE 12+ 17. Fether's Nema (First, Middla, Last) 18. Mother's Nema (First, Middla, Melden Sumema) Be MATTHEW VI REYNOLDS ANNA SCHIRLING 19b. Melling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) SteWArt-SON 2752 DAISY Wood BING MD 21797 Dr. JAMES 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stata 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State SPESUTIA CEMETERY 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funaral Service Licanua 23e. Pert1. Enter the disaesa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest,

Approximate **Physician** Immediete Ceuse (Finel disaese or condition rasulting in deeth) /Medical A/Zheimers Examiner Examiner attending physician and for use as the burial-transit certificate be executed Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Ceuse (Diseese or injury that initieted avants resulting in deeth) Last Dua to (or as e consequence of) Box 68760, Physician/Medicai Due to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ecent ò 24b. Were autopsy findings aveilebie prior to completion of cause of death? 24e. Wes en autopsy performed? Completed certificate 1 Yes 2 No 1 ☐ Yas 2 ☐ No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica funaral director, 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) Certification: 28d. Describe how injury occurred 28c. Injury et Work? 1 PNaturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 - Homicide Medicai 29e. Certifier 1 Certifying Physician: To tha best of my knowledge, deeth occurred et the time, dete end pieca, and due to the cause(s) end menner as steted. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and menner stated. 29c. Licansa number 29b. Signeture and title of cartifier 29d. Dete signed (Month, Dey, Year) 00053675 10 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) A-Monteleone 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature State MAR 0 9 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month DIMON C March /Medical 4c. County of Death 4e. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death Examiner Potomac Valley Nursing Home Rockville Montgomery 8. Data of Birth (Month, Day, Ye June 10 5. Social Security Number If Under 1 Year | If Undar 24 Hrs. Birthplaca (Stata or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□M 2□F XX Months Hours 579-20-9107 Yrs. Director 75 1928 Washington, Usual Residence of Decedant the Maryland 10e Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23s or 28s-f show 1 ☐ Yas 2 No Director MD Montgomery Bethesda 10e. Straat end Number 10f. Zip Coda 10g. Citizan of Whet Country? with 5225 Pookshill Rd. Funeral 20814 USA 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes ZONo If Yas, Giva Yeer or Datas: Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) Race - Amarican Indian, Bleck, Whita, atc. the Medical Examiner filed within 72 hours aftar 1 □ Navar Married 2 □ Married 21215-0020 6 þ 1 ☐ Yas 2 TNo Specify: White 3 ☐ Widowad ♣☐Divorced "natural", Completed 15. Decedant's Education 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry (Spacify only highest grada complated) Pages 1 end 2 should be filed within nent of Heelth end Mental Hygiena. ent: If item 27 is marked other than ' Elementary/Secondery (0-12) College (1-4or 5+) Secretary Vitro traumatic event. Baltimore, Maryland 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Surname) Goodman Kay Katie Chaikin 19a. fnformant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 s Department of Heelth er Important: If item 27 is any Injury or other trau Jerry Simon 14001 Parsippany Pl. N. Potomac, MD 20878 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Surlai 2 □ Crametion 3 □ Ramoval from Steta 4 □ Donation 5 □ Othar (Specify) King David Cemetery 3/5/99 Falls Church, VA 21. Signeture of Funaral Sarvice Licenses 22. Name end Address of Facility Takoma Funeral Home 254 Carroll St. Washington, DC 20012 Cas 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not anter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervel Batween Onsat and Death **Physician** /Medical Immediata Causa (Final Arteriosclerotic Vascular Disease disaasa or condition resulting in daath) Examiner Dua to (or as a consequance of): or Attending Physician: The lew requires that the death certificete be executed buriel-transit end Sequentially list conditions, if any, laading to immadiata ceusa. Entar Underlying Causa (Diseasa or Injury that Initiatad avants rasulting in deeth) Last Dua to (or es a consaguance of): Division of Vital Records, P.O. Box 68760. been signed by the attending physician should be datached for use as the burie Physician/Medical Dua to (or as a consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes XXNo 3 Probably 4 Unknown by Completed 24b. Wara autopsy findings eveilabla prior to completion of cause of daath? 24a. Wes en eutopsy performed? hes certificate 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No Be 25. Wes casa raterred to medical 28. Pleca of Daath (Check only one) Hospital: 2 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA this funaral 27. Mannar of Deeth Certification: 28e. Dete of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred After 5 Pending invastigation 1 ☐ Yas 2 ☐ No within 24 hours after death.
To the Funeral Director: A completely filled in by the fu death. 2 Accident 3 Suicida 6 Could not be 28e. Place of Injury - At homa, farm, straet, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida Hospital Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mennar as stated.

21 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Cartifian (Check only one) the 29b. Signatura 29c. Licansa number 29d. Deta signad (Month, Day, Yaar) D 01120 March 4, 1999 30. Nema and address of parson nted coupe of death (Item 23e) (Type, Print)
1299 Lambert Dr., Silver Spring, MD Walter Goozh, MD 31. Data filed (Month, Day, Year) MAR 0 5 1999

32. Ragistrar's Signetura

Registrar

State

And the state of t

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Death Dey Elizabeth Smith 27 02 99 9:25am 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Prince George's Prince George's Hospital Center Cheverly If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | 7/3/34 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplece (State or Foreign
Country) 1□ M 25 F 065-28-5510 64 Yrs. North Carolina Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Hyattsville Prince George's ¥ Yes 2 No 10e. Street end Number 10f. Zip Code 20784 10g. Citizen of Whet Country? USA 6902 Parkwood Street 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes ŽXNo Specify: **Black** Specify: 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry 15. Decadent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) Private Mental Health Specialist 12 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fether's Name (First, Middle, Last) unknown Odessa Bowden 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Ms. Barbara Chester (Daughter) 6902 Darkwood Street Hyattsville, MD 20784 20b. Plece of Diaposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, State Dete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 3/5/99 Chesapeake Crematory Beltsville, MD 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility J.B. Jenkins Funeral Home Na 7474 Landover Rd, Landover tercer MD 20785 cu 23a. Pert1. Enter the _____se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediate Cause (Final Acute Respiratory Failure diseese or condition resulting in deeth) Due to (or es e consequenca of): Bronch: tis Acute Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Advanced Chronic Obstructive Pulmonary Disease 23b. Did tobacco use contribute to the cause of death? Pert il. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 2□ No 1 X Yes 3 Probably 4 Unknown

Physician /Medical Examine

Examiner

Physician/Medical

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Completed

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Certification: To

Medical

permit. Pagas 1 and 2 should be filed within 72 hx. Department of Health and Mental hygiene. Important: If them 27 is marked other than "naturany injury or other traumatic avent, the Medical page.

Physician

/Medical

Examiner

10a State

Director

Funeral

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Funeral

Director

"natural", or items 23s or 28s-f show

the Marylend

With

72 hours after death

physicien end the buriel-transit 98 attending p signed by the a should i certificata has b director, this funaral in 24 hours efter deeth.

The Funeral Director: Af
Implately filled in by the fu

The law requires that the death certificate be executed

or Attending Physician:

Division of Vital Records, P.O. Box 68760.

25. Wes case referred to medical examiner?

Nopatient 2 ER/Outpatient 3 DOA

28e. Plece of injury - At home, farm, street, fectory, office building, etc. (Specify)

28b. Time of

28e. Date of Injury (Month, Dey Year)

24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24a. Was en autopsy performed? 275NO 1 Yes 1∏Yes 2∏No 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

3 ☐ Suicide 4 ☐ Homicide 29e. Certifier (Check only one)

1 Yes 2 No

27. Manner of Death

Naturel 2 Accident

Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner es steted.

Madical Examinar: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, date and place, end due to the cause(s) and menner steted.

28c. Injury at Work?

1 Yes 2 No

29b. Signeture and the of certifier

5 Pending

investigetion 6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year)

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

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-27-99

Louis Steinberg, M.D.

MAR 0 5 1999

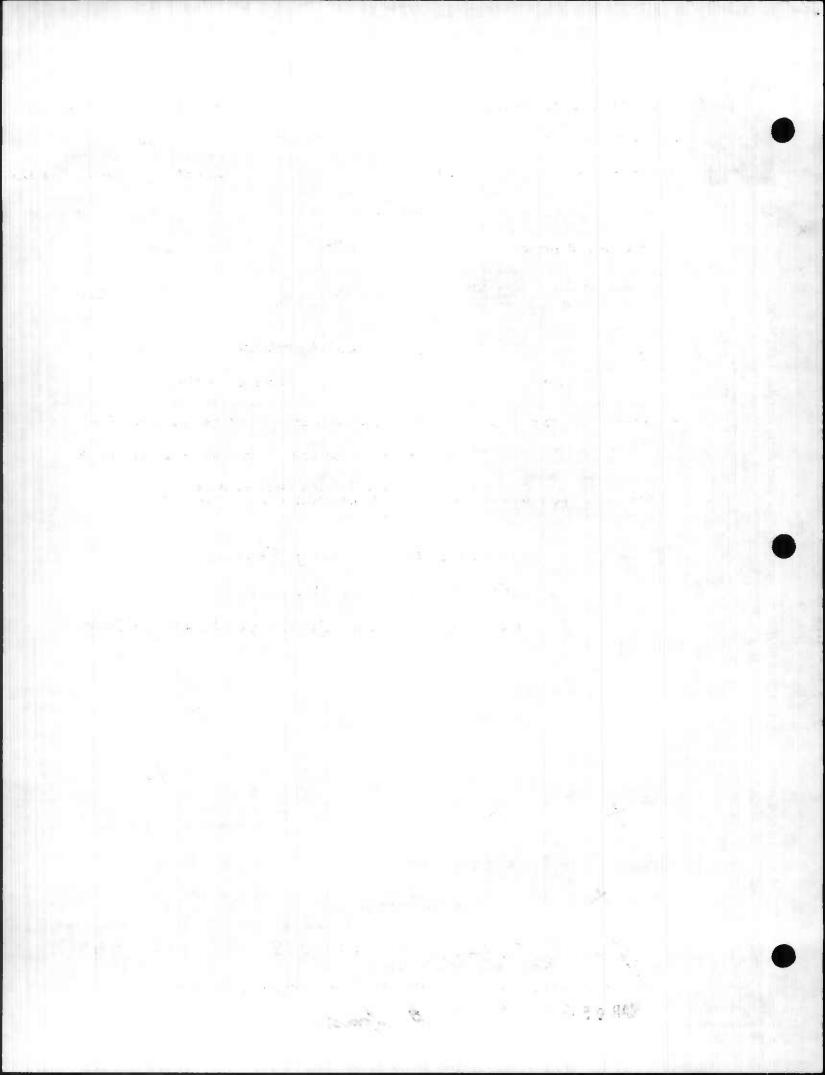
31. Date filed (Month, Dey, Yeer)

6492 Landover Road, Landover, Maryland

State Registrar 32 Registrer's Signeture

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath Gel 28 eb 4a. Facility Nama (If not institution, giva street end numbar) 4b. Cjty, Town, or Location of Daeth HVat HsVille 305 Calver 0 residenc LOUN 7. Aga (In yrs. last birthdey) 62 Yrs. If Under 1 Yeer A Undar 24 Hrs. 5. Social Security Number 6. Sax 15-0967 15 M 2 F Months Deys Hours Usual Rasidanca of Dacadent 10a Stata County 10c. City, Town or Location 10d. Insida City Limits 1 Dayas 2 No 10e. Straat and Numbar 10f. Zip Coda 10g. Citizan of What Country? 20783 er Salvador 12. Was Dacedent Evar in U.S. Armed Forcas? Wes Decedant of Hispenic Orlgin? (Spacify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 1 Navar Married 2 Marriad ☐ Yas 2 No Yas, Giva 3 ☑ Widowad 4 ☐ Divorced Specify: HISDANIC 15. Dacedent's Education (Specify only highast grade complated) 16a. Decedant's Usual Occupation (Giva kind of work done during most of lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elamantary/Sacondary (0-12) Collaga (1-4or 5+) 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumame) Jaravia ONSO DMasa Hraverra 19a. tnformant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Straet and Number or Rural M1.20783 elaya 5 a 20e. Mathod of Disposition 20b. Place of Disposition (Nama of camatary, cramatory or other place) Date . 1 Buriei 2 Cramation 3 Removel from State 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Address of Fecili WALTER 1 23a. Part1. Entar tha disaasa, or complications that caused the daath. Do not antar tha moda of dying, such as cardiac or raspiratory errast, shock, or haart failura. List only ona causa on aach lina. mntca Immediata Causa (Final disaasa or condition rasulting in daath) Dua to (or as a consequance of) Due to (or es e consequence of): Due to (or es e consaquence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy findings aveilable prior to completion of cause of daath? 24a. Was an autopsy performed? 1 ☐ Yas 2 ☑ No 1 Yas 202 No 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) Hospital: Othar: 4□ Nursing Homa 5 Masidance 6 □Othar (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after death w. Department of Heelth and Mental Hygiene. Important: If flem 27 is marked other than "natural", or items 23a any injury or other traumatic event.

Baltimore, Maryland 21215-0020

the Maryland

Examiner Sequantially list conditions, if any, laading to immadiata causa. Entar Undarfying Causa (Disaesa or injury that initiated avants rasulting in death) Lest

physician end s the burial-transit Physician/Medical Completed by Be Certification: To

ettending p 980

or Attending Physician: The law requires that the deeth certificate be axecuted

Division of Vital Records, P.O. Box 68760,

n 24 hours eftar d le Funeral Direct pletely filled in by Hospital Medical To the Fune To the within 2

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death.

Registrar

1 Yas 2 No 27. Manner of Death 1 Natural

3 Suicida

(Check only one)

29a. Certifler

5 Panding invastigation 2 Accidant 4 Homicida

6 Could not be datarmined

28a. Data of Injury (Month, Day Yaar)

28b. Tima of Injury

28c. tnjury at Work?

1 Yas 2 No 28a. Plece of Injury - At homa, farm, atreat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

28d. Describe how injury occurred

Certifying Phyeician: To tha best of my knowledga, daath occurred at tha tima, data and place, and due to tha cause(s) and mannar es steted.

| Medical Examiner: On the basis of axamination end/or invastigation, in my opinion, daath occurred at the tima, data and place, and due to the cause(s) and mennar stated. 29b. Signatura end title of certifian 29c. License number

29d. Deta signed (Month, Day, Year)

30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print) HYATSUILLE. MD. 20782 RA

BELLROS 7 31. Data filed (Month, Day, Year)

MAR 0 4 1999

32. Registrar's Signatura

The state of the s

1999

3. Time of Death

6:00 am

10d. Inside City Limits 1 Yas 2 No

Approximate Interval Between Onsat and Death

march 3, 1999

Birthplace (State or Foreign Country)

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2 **Physician** MARCH GEORGE WASHINGTON SINGLETON, SR. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner SOUTHERN MARYLAND HOSPITAL PRINCE GEORGE'S CLINTON if Under 1 Year if Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months Days Hours Min. Yrs. 578 03 8832 87 Sept. 5, 1911 SOUTH CAROLINA **Director** Usual Residence of Decadent Pages 1 and 2 should be filed within 72 hours after death with the Manyland nent of Health and Mental Hygiens. In the Manyland Hygiens. In this if them 27 is merked other than "natural", or items 23a or 23a-f ahow my or other traumatic event, the Manyland at my or other traumatic event, the Manyland at 10a State 10b. Count 10c. City. Town or Location Director WASHINGTON D.C. 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 2444 Ontario Road NW 20009 USA Funerai Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. Black, White, etc. 1 Navar Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 10th ADMINISTRATOR GOVERNMENT 18 Mother's Nama (First Middle Maiden Sumame) 17. Fathar's Name (First, Middle, Last) WILLIAM JAMES MAZURA SINGLETON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. tnformant's Name/Relationship (Type, Print) IRA BELLE SINGLETON WIFE 2444 Ontario Rd NW Washington DC 20009 20b. Place of Disposition (Name of cematary, cramatory or other placa) Date 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State 3-5-99 Suitland, Maryland Washington National Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility MARSHALL'S FUNERAL HOME OF MD 21. Signature of Funeral Service Licensee Kemberly Clauscoe -10mic 4308 Suitland Road Suitland, MD 23a. Part. Enter the diseasa, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Physician . Hyperusmola coma w. h. hyperglycemia /Medical Immediate Cause (Final disaasa or condition resulting in death) Examiner Due to (or as a consequence of):
Artivioscloration periphene vasule discur, love extremiting Examine physician and the burial-transit law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Entar Underlying Causa (Disaasa or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequenca of). signed by the a d be detached t

23b. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to

24a. Was an autopsy

completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was case rafarred to medical examiner? 26. Placa of Daath (Check only ona)

1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 Yes 2 No invastigation

6 Could not be datermined 3 Suicide 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicida 29a. Certifier

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. (Check only one) 29d. Data signed (Month, Day, Year) 29c. Licanse number 29b. Signature and title of cartkier

amen h D35206 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 Livingston Road, Fort WASHINGTON mg 20744 William T. TANNER, MD

Registrar

by

Completed

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Certification:

Medicai

31. Date filed (Month, Day, Year) WAR 0 4 1999

certificate has b

this funeral

after death

24 hours Funeral

To the Hosp within 24 ho To the Fune completely fi

or Attanding Physician:

2. Ragistrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3 Time of Death Month **Physician** RETH R. SCHIFFMAN February 25, 1999 4:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner 4c. County of Death 506 Park Road Rockville Montgomery 5. Sociel Security Number If Under 1 Yeer if Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Country) 1 M 2 TXF Months Deys Hours Min Yrs. Director 49 198-46-5309 Jan. 19, 1950 Washington, DC Usual Residenca of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 506 Park Road 20850 U.S.A. death 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. efter 1 ☐ Yes 2 🛣 No 1 Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by 3 Widowed 4 Divorced Yeer or Dates White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6th Grade Handicapp Program N.I.H. permit. Peges 1 and 2 should be flike Department of Heelth and Mental Hy Important: If Item 27 Is marked other eny Injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Benjamin Schiffman Dorothy Bramow 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14809 Pennfield Circle, Apt. 205, Silver Spring MD 20c. Location - City or Town, Stete 20906 Dorothy B. Schiffman, Mother 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 2/18/1999 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Memorial Garden Falls Church, Virginia 21. Signature of Fi STEIN "HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, N.W., WASHINGTON, D.C. 20012 e, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Heart Failure Examiner certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last pue Due to or es e consequence of Box 68760 physician Physician/Medicai the Due to (or as a consequence of): as ettending | P.O. | Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? peen eta hes t 1 Yes 2 No 1 Yes 22 No certificeta Division of Vital 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only oge) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this After this 27. Menne of Death 28a. Date of fnjury (Month, Day Year) Medical Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Attending 1 Naturel 5 Pending investigation s after death.

I Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide hours after Hospital or To the Hospital of within 24 hours at To the Funeral Completely filled 29a. Certifier The certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, end due to the ceuse(s) end menner as steted.

| Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, end due to the ceuse(s) end menner as steted. (Check only one) On the basis of exemination and/or investigation, in my opinion, death occurred at the time, dete end placa, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) 0

State Registrar

31. Date filed (Month, Dey, Year)
MAR 0 2 1999

Michael A. Dempsey, M.D., 14808 Physicians Lane, Suite 111, Rockville, MD 32/Registrar's Signature 1000

20850

and Same

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedant's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death Month **Physician** TRENE SMITH 11:00 AM /Medical 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Temple Hills Prince George's 2400 Foster Place 5. Social Security Number If Undar 1 Year | if Under 24 Hrs. 7. Aga (In yrs. last birthday) **Funeral** Data of Birth Birthpiaca (Stata or Foraign Country) 1 □ M 2 1 F Months Days Hours 2.42-28-2036 Yrs. Director 01-22-1924 Winston Salem NC Usual Rasidence of Decedant filed within 72 hours after death with the Meryland Hygiene. 10a, Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD Temple Hills Prince George's 1 X Yas 2 □ No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? or items 23s or 2400 Foster Place 20748 IISA Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11 Maritai Status 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: þ specify: Black 3 ☑ Widowed 4 ☐ Divorced "natural". Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry marked other than Eiamantary/Secondary (0-12) Collage (1-4or 5+) Teacher DC Public Schools permit. Peges 1 and 2 should be file Depertment of Heelth and Mentel Hy Important: if item 27 is marked othe any lollury or other traumatic event potes. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Be George B. Lowery Rhoda Stevenson 2 19a, Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Constance Givens-Jones 2400 Foster Place Temple Hills, MD 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify Rock Creek Cemetery 3-3-99 Washington, 21. Signature of Funarai Service Lice 22. Nama and Address of Facility
Tyrone J. Young Funeral Services 719 Kennedy Street, NW Washington, DC ntar the disease, or or heart failure. List s that caused tha dean. sa on each line. Do not entar tha mode of dying, such as cardiac or respiratory arrast, Approximata Interval Ratween Onset and Death Physician /Medical Immediata Causa (Final Squamous Cell Carcinoma, tongue 1 year disaasa or condition rasulting in daath) Examiner Dua to (or as a consequance of) Hospital or Attanding Physicien: The lew requires that the deeth certificate be executed Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Diseasa or injury that initiated events rasulting in daath) Last pue Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ettending physician for use as the buria Physician/Medical Dua to (or as a consequence of): been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Dementia, Alzheimer type þ Completed 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? hes page 2 certificate 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was case rafarred to medical Be 26. Placa of Death (Check only ona) axaminar? Othar: 4 ☐ Nursing Homa 5 ☐ Rasidence 6 ☐ Othar (Specify) 1 Yas 2 No 2 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Mannar of Death 28d. Describe how injury occurred 28b. Time of Certification: 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? After 1 X Natural 5 Pending death. 1 ☐ Yas 2 ☐ No invastigation 2 Accidant Director: in by the 3 Suicida 6 Could not be determined 28a. Place of tnjury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida within 24 hours eft To the Funeral Di completely filled in 29a. Cartifiar 🔯 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signatura and titla of certifian 29c. Licansa number 29d. Data signed (Month, Day, Year) 2-26-99 D01852 30. Name and addrass of person who completed cause of daath (Itam 23a) (Type, Print) Paul A. DeVore, MD 4203 Queensbury RD Hyattsville, MD 20781 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State MAR 0 2 1999 Registrar

DHMH 16 Rev 6/95

Mark .

State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Data of Death 1. Decedant's Nama (First, Middle, Last) 3. Tima of Death February 28, 1999 **Physician** 2:11pm HORNE SPICER, JR. CHARLES /Medical 4a. Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner DOCTOR'S COMMUNITY HOSPITAL LANHAM PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Sacurity Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
October 26,1921 Washington DC **Funeral** 1 M 2 □ F 77 Yrs. Director 578 16 4147 Usuel Rasidanca of Dacadant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits ahov 1 Yas 2 □ No Director 28a-f MARYLAND PRINCE GEORGE'S FORESTVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2211 OAK GLEN WAY 20747 USA Funeral 14. Race - Amarican Indian, Black, Whita, atc. 11 Marital Status 12. Was Dacedant Evar In U,S. Armed Forcas? Was Decedant of Hispenic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puarto Rican, atc.) ☐ Yes 2 ☐XNo f Yes, Giva 1K Nevar Marriad 2 Married ò 1 ☐ Yas 2 X No Specify: Specify: BLACK ò 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Business/Industry Hygiene. Elamantary/Secondery (0-12) Collega (1-4or 5+) 12th NATIONAL CAR RENTAL PRIVATE 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Mental B CHARLES H. SPICER, SR. JOSEPHINE IRBY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rurel Routa Number, City or Town, Stata, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If Nem 27 is any injury or other train CAROLYN J. BAILEY DAUGHTER 2211 OAK GLEN WAY FORESTVILLE, MD 20b. Placa of Disposition (Name of cematary, cramatory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) LINCOLN CEMETERY 3-5-99 SUITLAND, MARYLAND 21. Signature of Funaral Sarvica Licensea 22. Nama and Addrass of Facility MARSHALL'S FUNERAL HOME OF MD Buscoe tonic 4308 SUITLAND ROAD SUITLAND, MD 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart fellure. List only one cause on each line. Approximeta Intervel Batween Onsat and Death Physician . Carcinoma of Esophagus /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner Due to (or as a consequence of):
Datie melastasis The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leeding to immadiate cause. Enter Undarlying Cause (Diseasa or Injury that initiated avants rasulting in death) Last pue Physician/Medical neumonia Part II. Other algnificant conditiona contributing to death but not resulting in the undarlying causa givan in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown YUCI þ 24b. Wera autopsy findings evellable prior to completion of cause of daath? Completed 24a. Was an autopsy certificate hes nan 1 Yas 2 No 1 ☐ Yas 2 ☐ No spital or Attending Physician: Theoris effer death.
nerel Director: Atter this certificate y filled in by the funerel director, pe Be 25. Was casa referred to madical 26. Place of Deeth (Check only ona) Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 2 1 Yas 2 No 1 ■ Inpatient 2 □ ER/Outpatlent 3 □ DOA 28a. Dete of Injury (Month, Day Year) 27. Mannar of Deeth 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 1 Matural 5 Pending Invastigation 1 Yas 2 No 2 Accidant 6 Could not be datermined 3 Suicide 28e. Placa of Injury - At home, ferm, straat, factory, office building, atc. (Specify) Location (Streat and Number or Rurel Route Number, City or Town, Stata) 4 Homleide Hospital c 24 hours e Funerei D 29a. Cartifian 1 Certifying Physician: To the best of my knowledga, deeth occurred et the tima, data and placa, and dua to the cause(s) and menner es stated.

2 Medical Examinar: On the basis of axamination and/or investigation, in my opinion, daath occurred et the time, date end placa, and dua to the cause(s) and manner stated. Medical To the 29b. Signatura and title of certifian 29d. Data signed (Month, Day, Year) 29c. License number 30. Name end eddrass of person who completed causa of daath (Itam 23a) (Type, Print)

Dv. SHRINIVAS R. UDAPI. 7245B HANOUER PKWY. GREENBELT. MD 31. Date filed (Month, Day, Year) 32. Registrer's Signatura State MAK 0 % 1999

Registrar

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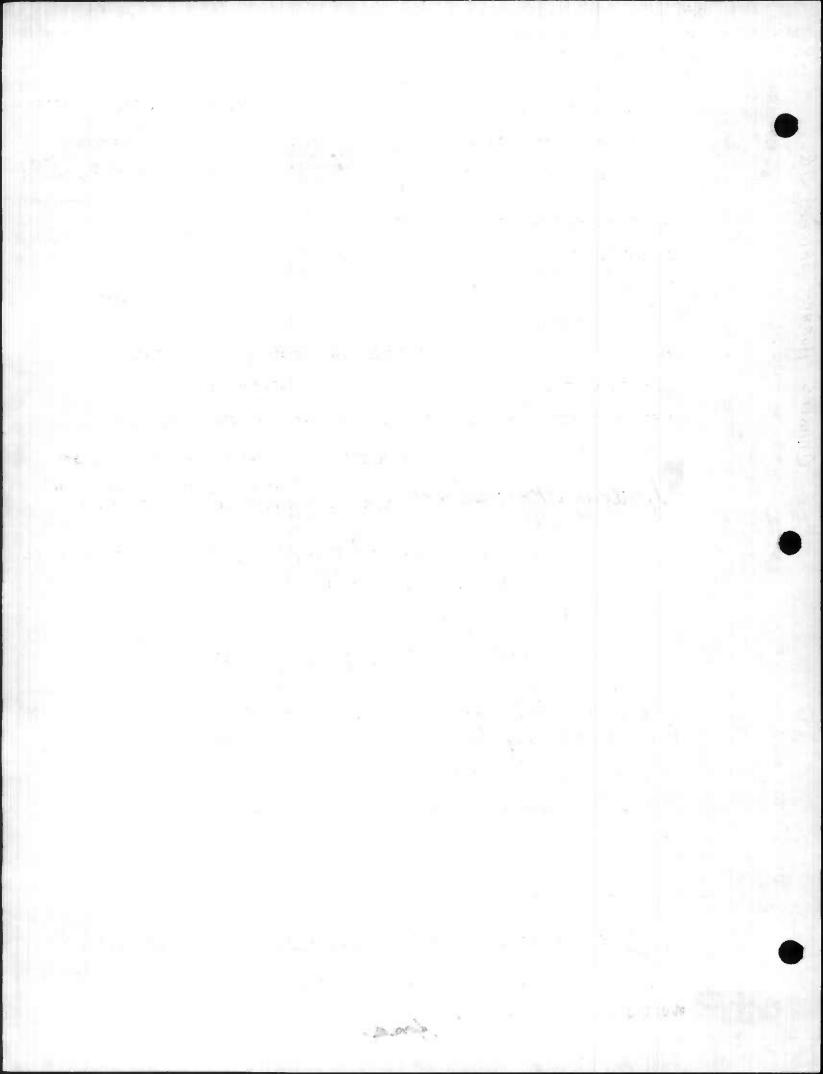
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Maryland

Baltimore,

P.O. Box 68760,

Division of Vital Records,



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month CATHERINE ELIZABETH SHANK 3,1999 7:40 PM. March 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death RETIREMENT VILLAGE WASHINGTON WILLIAMSPORT WILLIAMSPORT If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Yaar 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) 1 M 2 N F Months Days 84 Yrs 28, Maryland 10d. Inside City Limits 10h County 10c. City, Town or Location Yas 2 No Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 21740 USA 341 Radcliffe Avenue 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Dates: 14. Raca - American Indian, Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ☑ Widowed 4 ☐ Divorced 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast greda completed) Cotlege (1-4or 5+) Elementery/Secondary (0-12) presser dress mfg. 18. Mother's Nema (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Cora Emiline Easterday John Emory O'Neal 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rt. 4, Box 284 B., Martinsburg, W. Va. 25401 Myrtle V. Snow - niece 20b. Place of Disposition (Neme of cametery, cremetery or other place) 20c. Location - City or Town, State 1X Buriat 2 ☐ Cramation 3 ☐ Removal from Stata Cedar Lawn Mem. Park 3-6-99 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility 21. Signature of Funeral Service Licansee MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740 mula 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onsat and Death ASPIRATION PNEUMONIA 2 DAYS Due to (or as a consequence of): CEREBROUASCULAR ACCIDENT Due to (or as a consequenca of) HYPERTENSION Due to (or as a consequence of): 23b. Did tobacco use contribute to the ceusa of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an eutopsy performed?

Physician лиесісы Examiner

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To the Hospital or Atta within 24 hours efter de To the Funeral Diracto completely filled in by th

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Division of Vital Records, P.O. Box 68760,

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Certification:

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Physician

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"natural", or itams 23s or 28s-f show

Pages 1 and 2 should be filed within 72 hours effer can neat of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or iter may or other traumatic event, Ite Magical Expensive my or other traumatic event, Ite Magical Expensive Insurance.

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

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death

5. Social Security Number

219-14-8085

10e State

Maryland

11 Marital Status

10e. Street and Number

Usual Residence of Decedent

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final

disease or condition resulting in death)

20a. Method of Disposition

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

VASCULAR DEMENTA; INSULIN DEPENDENT

DIABRIES MELLITUS

25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident

6 ☐ Could not be determined 3 Suicide 4 Homicide

28a. Date of Injury (Month, Dey Year) 28b. Time of

28e. Ptace of Injury - At home, farm, street, factory, offica building, etc. (Specify)

26. Place of Death (Check only one) Other: 420 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred

1 Ves

28f. Location (Street end Number or Rural Routa Number, City or Town, Stete)

2. No

29a. Cartifier (Check only one)

15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) end manner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and titte of certifier

29c. License number

1 Yes

29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

STAFF PHYSICIAN

D42046

MARCH 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREE BROOKE HUFFMAN, M.D. 18100 SLADE SCHOOLLO AS SANDY SPRING MARYLAND 20860

State Registrar

31. Data filad (Month, Day, Year) MAR 0 5 1999

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** 1999 March Bernice Mae Snare 9:15 am /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Williamsport Nursing Home Williamsport Washington Hours Min. Feb. 3, 1 2947 If Under 1 Yaar 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign Pennsy I van i a **Funeral** Months Days 1 ☐ M 2 👿 F 92 Yrs 216-22-7679 Director Usual Residence of Decedent with the Manylend 10a, State 10c. City, Town or Location 10d. Inside City Limits nd 2 should be filed within 72 hours efter death with the Marylen than Mental thyglene.

77 le marked other than "natural", or items 23e or 28e-f show traumatic event, the Mental traumatic event, the Mental traumatic event, the Mental traumatic event, the Mental traumatic event, the Mental traumatic event, the Mental traumatic event, the Mental traumatic event, the Mental traumatic event, the Mental traumatic event, the Mental traumatic event, the Mental traumatic event, the Mental traumatic event, the Mental traumatic event the Mental traumatic event, the Mental traumatic event, the Mental traumatic event event even 1 Yes 2 □ No Director Mary land Washington Williamsport 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 154 North Artizan Street 21795 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yas, Giva 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 No Specify: PV 3 Widowed 4 □ Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8 Inspector Label Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surname) Wesley Dorman Grace Conrad Russell 2 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 st of Heelth ar if item 27 is or other tr Carol Miller/Per.Rep. 131 East Potomac Street Williamsport, Maryland 21795 20a. Method of Disposition

Was Burial 2 Cremation 3 Ramoval from Stata 20b. Placa of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State Date Pages 1 permit. Pages Department of Important: If its any injury or o Greenlawn Memorial Park 3-12-99 Williamsport, Maryland 4 ☐ Donation _ 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Osborne Funeral Home 425 S. Conococheague St.Williamsport, MD 21795 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart laws. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) DEHYDRATION DAYS Examiner Due to (or es a consequence of): Examiner HUDREXIA WEEKS ettanding physician and for use as the burial-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Undarlying Cause (Disease or Injury that influence are 1 Due to (or as a consequenca of): PELVIC MALIGNANCY MONTHS Box 68760 certificata be Physician/Medical that initiated events resulting in death) Last Dua to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by 1 Yes 2 No 3 Probably 4 Unknown ADN ANCED SEVILLE DEMENTIA Records. þ 2 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy Completed peed has 1 Yes certificata 2 No 1 ☐ Yas 2 ☐ No Division of Vital director, 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Attending 1 Natural 2 Accident 5 Pending death. e Hospital or Attendion 24 hours effer death. Funeral Director: A 1 Yas 2 No Invastigation the 3 Sulcida 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as atated.

Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) To the To the To the F 29b. Signature and title of 29c. Licanse number 29d. Date signed (Month, Day, Year) MARCH 10, 30. Neme and eddress of parson who completed cause of death (Item 23a) (Type, Print) Boonsboro, MD 21713 75,42 Overlook Dr.

State Registrar m.0.

32. Registraria Signature

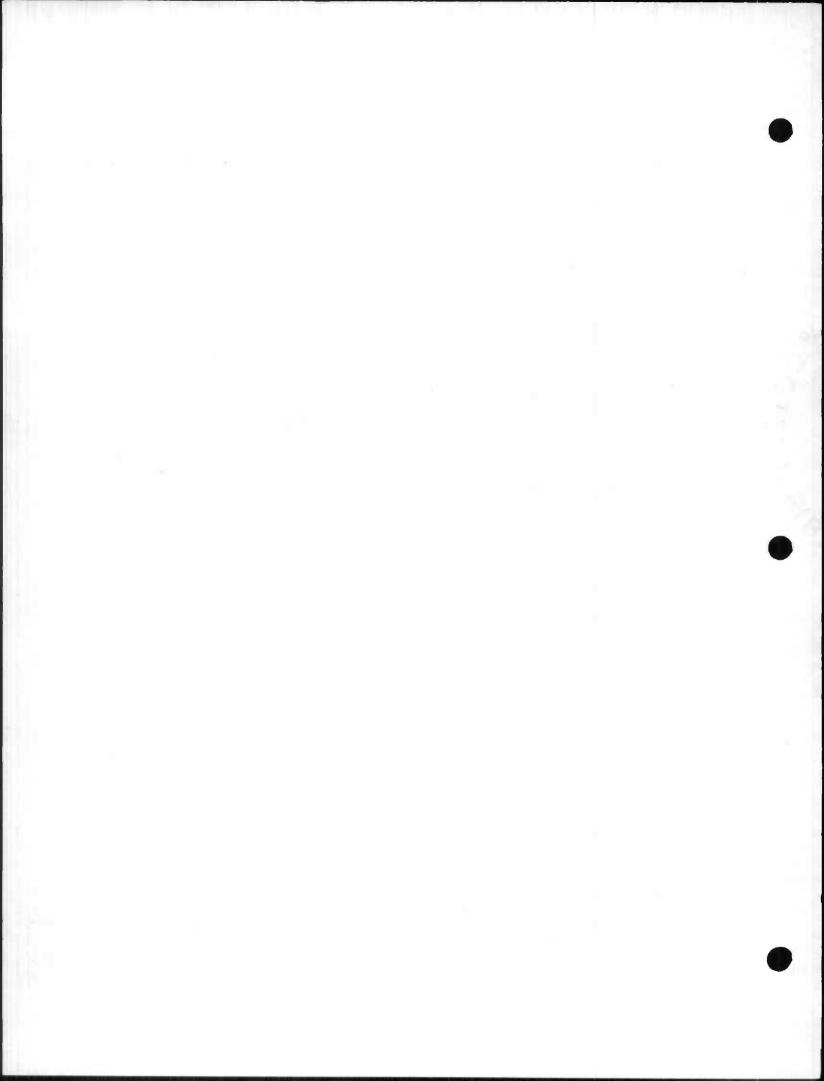
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BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the	2	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA		MENT OF H		MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	Ralph William SHA	VIK				March 9	1999	212 0 M
Ì	4. SOCIAL SECURITY NUMBER		n yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State or Foreign
	215-36-7035	1 M 2 □ F 68	YRS.	MONTHS DAYS	HOURS MIN.	(Month, Dey, Year) May 23 19	30 M	aryland
~	9a. FACILITY NAME (If not institution, give a	treet end number)		9b. CITY, TOWN O	R LOCATION OF DE	ATH	9c. COUNTY	OF DEATH
DIRECTOR	18811 Wagaman Road	d		Hager	stown		Washi	ngton
Ä	10e. STATE 10b. COUNTY	1	10c. CITY,	TOWN OR LOCAT	ION			10d, INSIDE CITY LIMITS?
0	Maryland Washi	ngton		Hagerst	own			1 YES 2 NO
AL	10e. STREET AND NUMBER			101	ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
FUNERAL	18811 Wagaman Road	d			21740		U.S.	Α.
5	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED			IIC ORIGIN? (Specify Ve	s or No- 14.	RACE — American indian, Black, White, etc.
BYF	1 Never Married 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DA			2 NO Specify	n, Puerto Rican, etc.)		Snacib:
	3 XI widowed 4 Divorced							White
三	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DECEDENT'S U	ork done during mo-		16b. KIND OF BU	SINESS/INDUST	TRY
"	Elementary/Secondary (0-12)	College (1-4 or 5+)	We. Do NOT use					
COMPLETED	12	0	Dairy	Farmer		Dairy		
8	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Malden		
BE	William Ivan Shar	nk			Mary Ha	nna Beckle	У	
0	19e. INFORMANT'S NAME (Type/Print)					Route Number, City or Tov		
	Ralph W. Shank, J.	r.	1880	8 Wagam	an Road			yland 21740
	20e. METHOD OF DISPOSITION 1 String Burlel 2 Cremetion 3 Rem	oval from State cem	etery, crematory or other Refo	F DISPOSITION (Na per place)		1	CATION — City	
	4 ☐ Donetion 5 ☐ Other (Specify) 21, SIGNATURE OF FUNERAL SERVICE LIC		ilem Refo					wn, Maryland
	.1	4				CILITY Minnio		
	fred I	Westel		415 E	. Wilson	Blvd. Ha	gersto	wn, Maryland
CERTIFICATION	23. PART t. Enter the diseasee, or o shock, or heart failura. IMMEDIATE CAUSE (Finel disease or condition resulting in daath) Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury	a. DUE TO (OR AS A DUE TO (OR AS A C.	CONSEQUENCE OF	Pauking ::			ratory differ	Approximate Interval Batween Onset and Death
RTE	that initiated eventa resulting in death) LAST	doe to (on as a	CONSEQUENCE OF):				
	DART II Other elevisions and dise							
PHYSICIAN: MEDICAL	PART II. Other algoriticent condition DID TOBACCO USE CONT	-				PERFO	RMED?	24b, WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
Y	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT					
Sic	EXAMINER?	HOSPITAL: 1 Inputient 2 ER/Outp		OTHER:	e 5 Residence	e Other (Specify)		
H	27. MANNER OF DEATH	200. DATE OF INJURY	26b. TIME	OF 26c. INJ	URY AT	28d. DESCRIBE HOW	INJURY OCCUR	ED
	Natural 5 Pending	(Month, Day, Year)	JUNI		YES 2 NO			
Э ВУ	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY building, etc. (Spec	- At home, ferm, st	treef, factory, offic	•	261. LOCATION (Street		Rural Route Number,
Ë	4 Homicide determined	bunding, etc. (Spec	агу)			City or Town, State)	
COMPLETED	(one only	ICIAN: To the best of my know						suse(s) and manner as stated.
BE C	296. SIGNATURE AND TITLE OF CENTURE	R 110			29c. LICENSE NUI	MBER	29d. DATE SI	GNED (Month, Day, Year)
TO B	(/X'//	Telecla Box			0110	266	3	110/99
-	30. NAME AND ADDRESS OF PENSION WH	Weeks M.	D 58	Print)	Thein	Ar Hos	RISTO	w, kl
	31. DATE FILED (Month, Day, Year) MAR 1 0 199	32. REGISTRAR'S SIGN		Spark		/		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death MARCH Betty Jane Snowberger 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Deeth 4c. County of Deet Washington Washington County Hospital Hagerstown If Under 24 Hrs. 9. Birthplece (State or Foreign Country) Maryland If Under 1 Year 8. Date of Birth (Month, Pay, Aug. 28, 5. Social Security Number 7. Age (In yrs. last birthday) Months Days 1 M 2 F 219-20-4583 71 Usual Rasidence of Decedent 10c. City, Town or Location 10d. Insida City Limits 1 Yes No Md. Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 307 Beaver Creek Rd. U.S.A. 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Dates: 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Merried 1 ☐ Yas 2 ☑ No Specify specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Nurse Nursing Home 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Frances G. Kindle Frank Benjamin Howe 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Mary F. Punt (Daughter) 415 Bethlehem Ct. Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Green Hill Cemetery March 12, 1999 Waynesboro, PA Domuion 5 Other (Spe Signature of Funeral Se 22. Name and Address of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediete Cause (Finel disaase or condition resulting in death) Merlopuea Due to (or as e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseesa or Injury that initiated events resulting In death) Last Due to (or es e consequence of) Dua to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other elanificant conditions contributing to death but not resulting in the underlying cause given in Part I.

Physician /Medical Examiner

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'natural', or Items 23s or 28s-f show

other traumatic avent, the Mexical Examiner must be notified at

permit. Peges 1 end 2 should be filed within 72 hours after Department of Health end Mental Hyglene. Important: If item 27 is marked other than "natural" or language.

Baitimore, Maryland 21215-0020

Examiner Physician/Medical Be Completed by

attending physician and for use as the burial-tren Division of Vitai Records, P.O. Box 68760 page 2 should be detact or Attanding Physician: Medical Certification: To To the Hospital or Attandiwithin 24 hours after deeth.

To the Funeral Director: A completely filled in by the f

SNOWBERGER, Beth, J

					17 Yee	2□ No	3 Probably 4 Unknown
					24a. Wes an aut performed?		24b. Were eutopsy tindings available prior to completion of cause of death?
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axaminer? 1 ☐ Yes 2 ☐ No	Hospitel: 1 Thpatient 2	ER/Outpetient 3E	DOA	Other: 4 Nursing	Home 5 Residence	6 □Oth	er (Specify)
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State Registrar

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

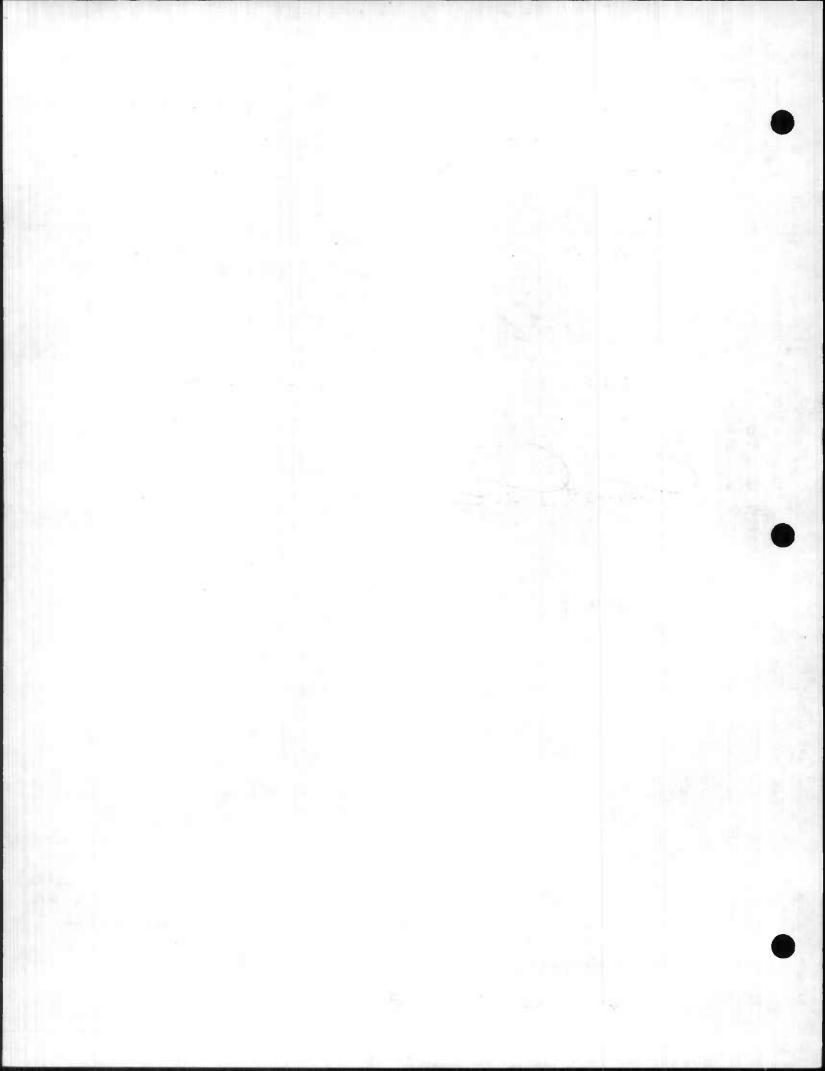
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ORIGINAL

31. Date filed (Month, Day, Year) 1999

29b. Signature and title of certifie

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 03:15 **Physician** Laurin Merrill Schick March 06 1999 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Washington County Hospital Hagerstown Washington County | H Under 1 Yeer | H Under 24 Hrs. | 8. Date of Birth (Month, Dey, Aug. 23, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1₩ M 2□ F 210-05-0440 81 Director New Mexico Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Washington County 1 ☐ Yes 2K No Hagerstown 28a-f Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 1057 Carroll Heights Boulevard 21742 USA Berns 23s 12. Wes Decedent Ever in U,S.
Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian 11. Meritel Status Bleck, White, etc. 1 GYes 2 No 10/1/61 1 Yes 2 No Specify: Year or Detes: 8/1/62 1 Never Merried 2 Merried 'natural', or Baltimore, Maryland 21215-0020 White Specify: 3 ☐ Widowed 4 ☐ Divorced 8/1/62 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Bustness/Industry 15. Decedent's Education (Specify only highest grede completed) Hygiene. College (1-4or 5+) Elementery/Secondery (0-12) Instrument Engineer Aircraft Manufacturing 12 4 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental h and Mental I Guy Albert Schick Effie Cleota Powell 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 21742 19e. tnforment's Neme/Reletionship (Type, Print) Elizabeth Martin/Caregiver 14121 Paradise Church Road, Hagerstown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Lawn Memorial Park Mar. 8 Hagerstown, Maryland 21. Signeture of Funeral Service Licensee 22. Neme end Address of Fecility Douglas A. Fiery Funeral Home 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 Approximete Interval Between Onset and Death **Physician** EMPHYSEMA /Medical tmmediete Ceuse (Finel diseese or condition resulting in deeth) Examiner Examine Sequentially list conditions, if eny, teeding to immediate cause. Enter Underlying Cause (Disease or thjury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of) 980 Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? TACHYCARDIA VENTRICUL AR 1 Yea 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: 2 ER/Outpatlent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 this 28a. Date of tnjury (Month, Dey Year) 27. Menner of Death 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how Injury occurred 1 Neturel
2 Accident 5 Pending investigation Division Attending To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 29e. Certifier Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edicai (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

State Registrar

29b. Signeture end title of certifier

Matthew G.

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

Bechwith,

th Day Year)

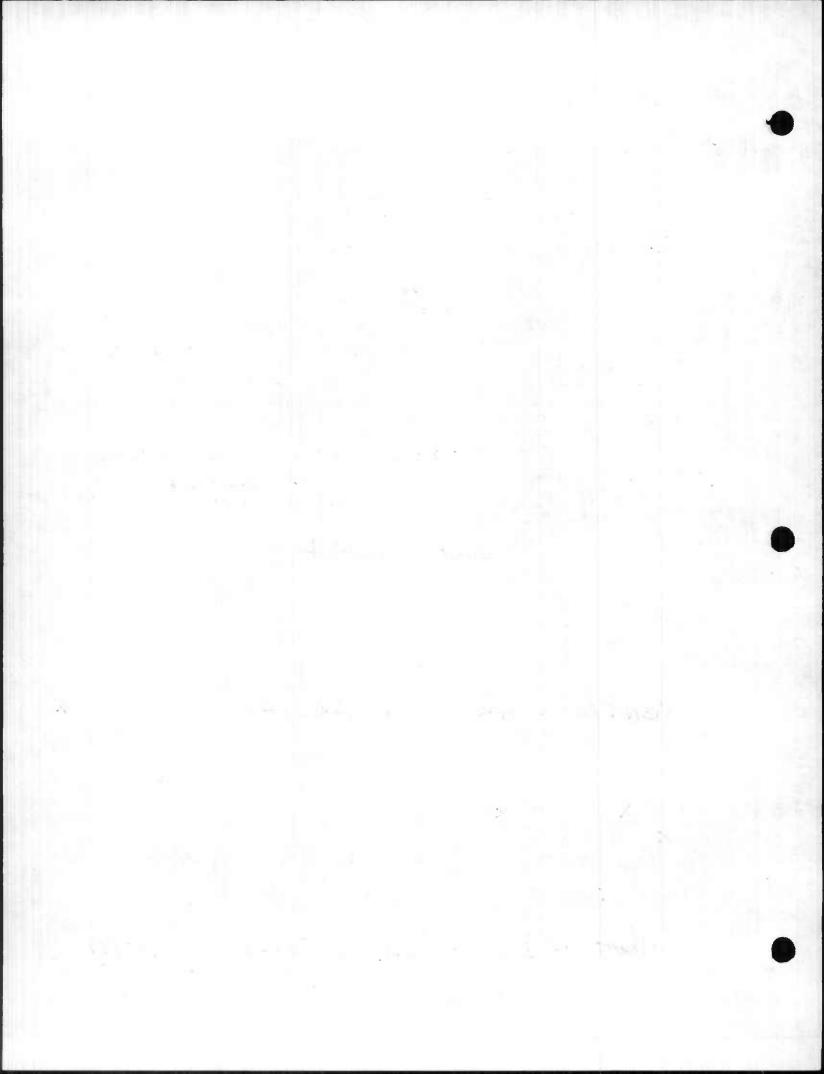
53634

MD, Robinwood Family Practice, 11110 Medical Campus

32. Restantiate S. Aparks

Hagerstown, Maryland 21742

29d. Date signed (Month, Dey, Year)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent'a Nama (First, Middia, Last) 2. Data of Death **Physician** /Medical 4a. Facility Nama (If not Institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NTGOHER TISTI If Undar 1 Year If Under 24 Hrs. 6. Sex 8. Date 5. Social Sacurity Number 7. Age (In yrs. last birthday) aca (Stata or Foreign **Funeral** Days 230-10-1 MM 2□ F Director Usual Rasidance of Decedent death with the Marylend 10a State 10b. County 10c. City, Town or Location IOd. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified at 1 Yas 2 00 Director ON 10a. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 Decedent Evar in U,S. 1 Decedent Evar in U,S. 1 Decedent Evar in U,S. 1 Decedent Evar in U,S. 11. Maritai Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) Race - American Indian, Biack, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer on Department of health and Mentel Hyglene.

Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Management. 1 Navar Married 2 Married 1□ Yas 2No Baltimore, Maryland 21215-0020 ρΛ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation
(Giva kind of work done during most of working
jiffa. DO NOT usa retired) 15. Decedant'a Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) 100V 18. Mothar's Nama (First, Middla, Maidan Surnama) 17. Fathar's Nama (First, Middle, Last) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 20b. Pleca of Disposition (Name of complary, crematory or other p 20e. Method of Disposition Date 20c. Location City or Town, State Burial 2 Cramation 3 Ramoval from State 4 Donation 5 Othar (Specify) 21. Signature of Funeral Sarvice Licenses WORTH enli for confilications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, ist only one cause on each line. Approximata Intarval Between Onset and Death Physician /Medical Immediate Causa (Final Felcys disease or condition rasulting in death) meumoni Examiner bue to (or as a consaquance of): Examiner ed by the ettending physician and detached for use as the burial-transit Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disease or Injury that initioted events resulting in death) Last Dua to (or as a consequence ot): Records, P.O. Box 68760 Physician/Medical Due to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1 Yee 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? this certificate hes 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case rafarred to medical examinar? funeral director, 28. Placa of Death (Check only ona) 1 Yas 2 No Othar: 4 ursing Home 5 ☐ Residence 6 ☐ Othar (Specify) 0 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Yaar) 27. Mannar of Daath Certification: 28b. Time of Injury 28c. Injury at Work?/ 28d. Describe how Injury occurred 5 Panding Invastigation of a Attending Perfector: After the 1 Nampal 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicida 28t. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of injury - At homa, tarm, streat, tactory, office bullding, atc. (Specify) 4 Homicida To the Hospital of within 24 hours of To the Funeral D 29e. Certifiar (Check only one) 1 Certifying Physician: To the best of my knowledge, dasth occurred et the time, dete end plece, and dus to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dasth occurred at the time, dete and plece, and dus to the cause(s) and manner stated. Medical 29b. Signature and titla of certifian 29c. Licansa number 29d. Data signed (Month, Day, Year) MO 0000535 30. Nama and addrass of person who complated cause ot death (Itam 23a) (Type, Print) tur, ma eld Mod

DHMH 16 Rev 6/95

State

Registrar

31. Data filed (Month, Day, Year)

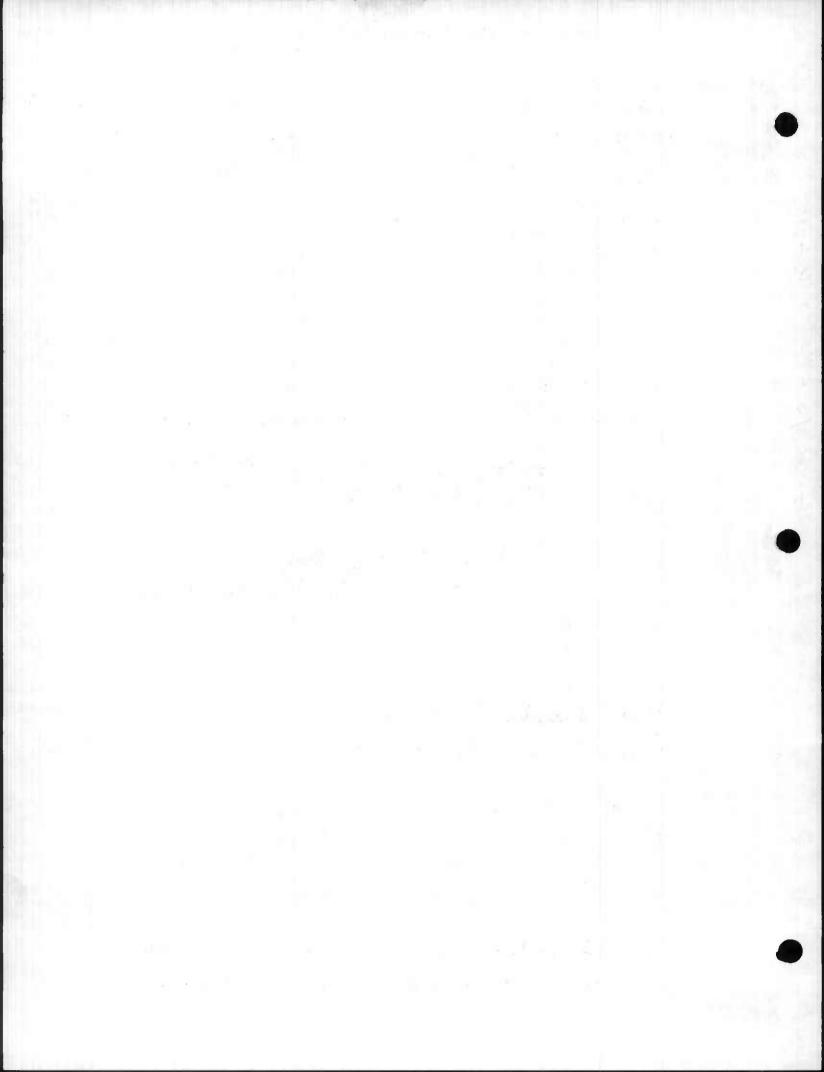
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\$2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 08883

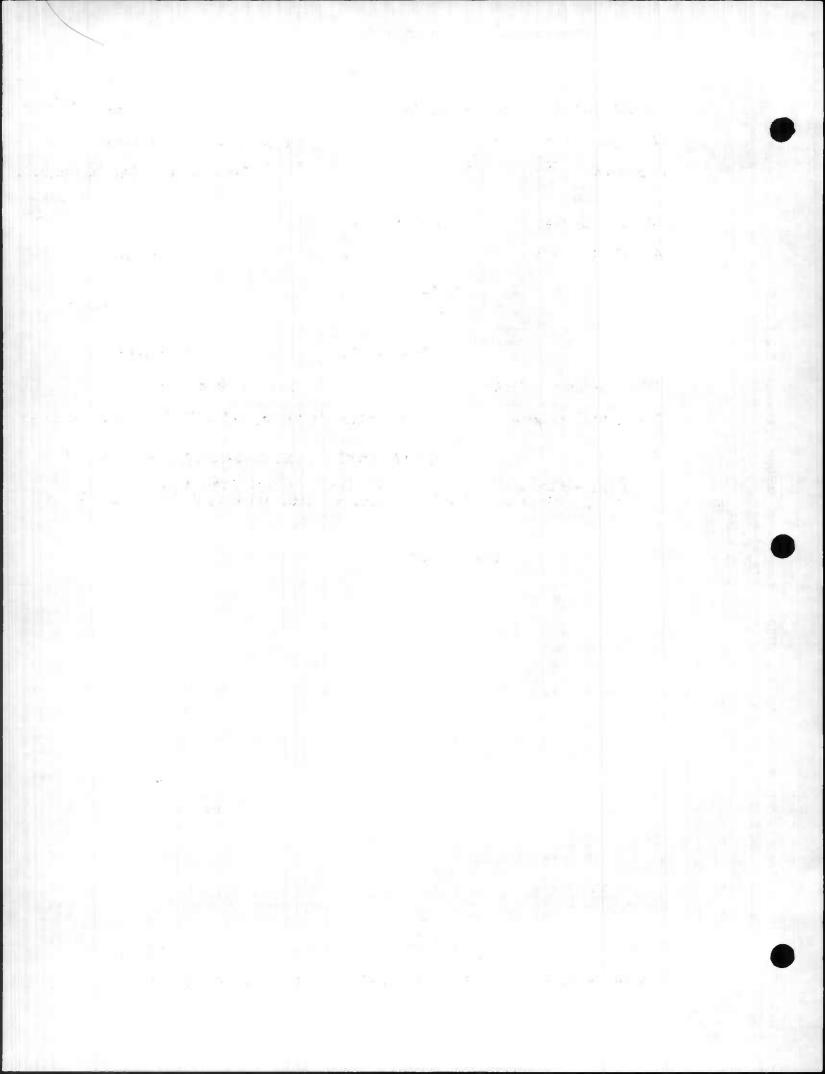
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/Medi		GLADYS	EDELEN		WILLIA	MS				MARCH	1 6	1999		A:M
Exami	ner	4a. Facility Name (If not institution CIVISTA MEDIC					4	b. City, Tov LAPI		ocation of Deat		nty of Death CHARLI		
Funeral Director		5. Social Security Number 578-12-2951	6. Sex 1 □ M 2 □ F	7. Aga (In yrs. 97	last birthday) Yrs.		Year Days	If Under 2 Hours	Min.	8. Data of Bi (Month, Di Dec. 19	1901	9. Birth Cou Mary	placa (State ntry) and	or Foreign
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with the	Funeral Director	10e. Street and Number 6000 Marshside	e Place			10f. Zip Co					10g. Citizen o		ntry?	
ified within 72 hours after death with the Maryland Hygiene. thysiene. ther than "natural", or items 23s or 25s-f show ont, the Medical Examiner must be incittled at	by	11. Marital Status 1 □ Never Married 2 □ Mar 3 ☑ Widowed 4 □ Divorced	Armad F	2)(1) No Give	,S. 13.	Was Dacedan if Yes, specify	_	ispanic Orig n, Mexican, Specify:	gin? (Sp , Puarto	ecify Yas or No Rican, etc.)		ace - Amari lack, White, cify: Whi	etc.	
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end 2 sho salth and 1 127 is me or traume		19e. Informant's Name/Relations Mary Ellen Karw		aughter							e, Mary		2069	3
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To the Hospital or Attendit within 24 hours efter death. To the Funeral Director: All completely filled in by the tu		4 Horricide		ding, etc. (Specif	v)			ne, date and	d place.		wn, State)	manner as	stated.	
in 24 h	edical		Examiner: On the											(s)
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		30. Name and address of person HENRY L BURKI		use of deeth (Item 5-A LA C	1 - 1 - 1		· ^	ROY	252	9 LAPL	ATA MD	2064	6	
Sta Regist		31. Date filed (Month, Day, Year)	9 1999 ^{32.}	Registrar's Signa	ture		,	. DOA	433	7 LAFL	ATA EID	2004	0	



State of Maryland / Department of Health and Mental Hygiene 9

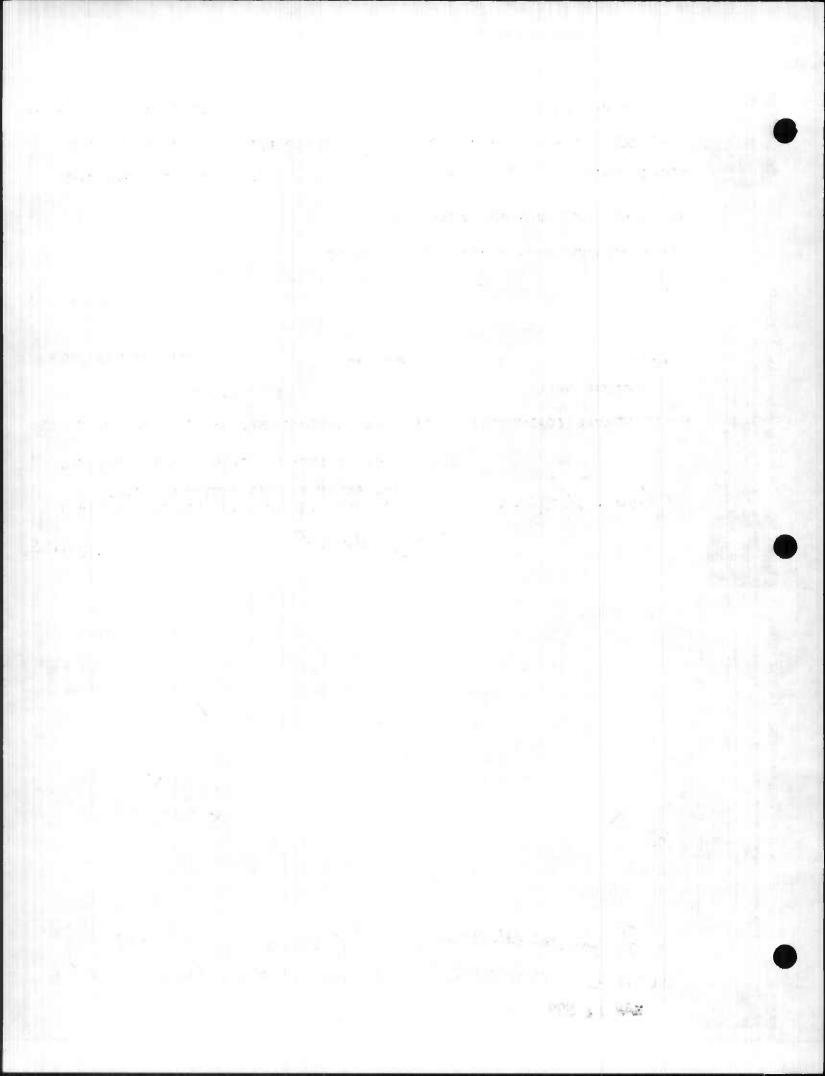
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or de	Funeral	11. Meritel Status	12. Was Deceda Armed Force	s?		Was Decedar If Yas, specify	t of Hi	ispanic Orig n, Mexican,	Puarto R	ify Yes or No icen, atc.)		ce - Ameri sck, Whita,	can Indien, atc.		
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7		30. Nama and addrass of person wh KRISHAN MATHU	R MD	P.O.	BOX	2729	T. 7	A DT.A	ጥል	MD	20646				
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9

				Certific	ate of	Death	F	leg. No.		
	1. Decedent's Name (First, Middle, L	ast)					2. Dete of Dee Month		Yeer	3. Time of Death
Physician /Medical	MABEL WE	LLS					FEB. 28		1991	6:45 pm
Examiner	4a Facility Name (If not institution, g	ive street and number)			4b. City, Town,	or Location of Death	4c. County	of Death	v. so put
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Funeral		Sex 7. A	ge (In yrs. last bii	Mont	nder 1 Year hs Deys		fin. 8. Dele of Birth	1		ace (State or Foreign
Director	218-26-6680	IUM ZQE	67	Yrs.			NOV. 1		MARYL	AND
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ma 23	11. Meritel Stetus	12. Was Decedent				Hispanic Origin?	(Specify Yes or No- uerto Rican, etc.)		JS e - America	n Indien,
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by by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□ Ye	s 2 XNo	Specify:		Specify	BL	ACK
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is me	19e. Informant's Name/Reletionship			. Mailing Add	ress (Street	end Number o	r Rural Route Numbe	r, City or Town,	Stete, Zip (Code)
	ROSIE GRAVES (DAUGHTER		02 B.	COP	ELAND	ST. ANNA	POLIS,	MD.	21401
If item 27 or other to	20a. Method of Disposition 1 Surial 2 Cremetion 3	□Removal from State	cemete	f Disposition (ry, crematory		ice)	Dete	20c. Location -	City or Tow	vn, State
4 # 9	4 □ Donation 5 □ Other (Spec		HILL	CREST	CEM	ETERY	3/3/99	ANNAPO	LIS.	MD.
Depertmen Important: any injury once.	21. Signature of Funeral Service Lic	ensee				ess of Fecility				
Q = 2 9	Lavry 4.	Reese		WM.	REES.	E & SO	NS MORTU	ARY, F	P. A.	
1000	23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause	d the death. Do	not enter the	node of dyl	ng, such as car	diac or respiratory an	LIS, N	1D. T2	Approximate Intervel Between
hysician	Shook, of Hour temore. List of	y one oads on door	1 121	11 (2110	00				Onset end Deeth
Medical	Immediate Cause (Finel disease or condition		Lou	ng Co		V			1	3 mos.
aminer	resulting in death)	θ	Due to (or as e	consequence	of):					
Te Te	termina and a								i	
ng physicien end ses the buriel-transit Medical Examiner	Sequentially list conditions,	0.	Due to (or as a	consequence	of):					
uniel uniel	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
physicies the bu	thet initiated events resulting in death) Last	C	Due to (or es e	consequence	of):					
Me es										
ed by the ettendir deteched for use / Physician/A		u								
the e	Part II. Other significant conditions	contributing to death I	out not resulting I	n the underlyi	ng cause gi	ven in Part I.	23b. Did t	obacco use co	ntribute to	the cause of death?
d by letecl	The second second						1)X1	res 2□ No	3 Prob	ably 4 Unknow
58 5	,						_		Total Mari	re autopsy tindings
should should leted							24a, Was a	med?	avai	ilable prior to
2 S D									of d	eath?
page Con							1 🗆 Y	es 20 No	10	Yes 2□No
Se Stor	25. Wes case referred to medical examiner?						Deeth (Check only o	ne)		
this ceral dire	1 Yes 2 No	Hospitel: 1 ☐ Inpat		utpetient 3	DOA Ot	her: 4 Nursir	ng Home 5 Resid	ence 6 Oth	ner (Specify,)
ector: After the by the funeral Hication:	27. Menner of Death 1 Natural 5 ☐ Pending	28e. Date of Inj (Month, D	ay Year) 28b.	Time of Injury	28c. inju	ry at	28d. Describe h	ow injury occur	rred	
deeth.	2 Accident investigat			М	1 [Yes 2 No				
rs efter deeth. al Director: After ti ed in by the funera Certification:	3 Suicide 6 Could not determine	Zoe. Piece of in	jury - At home, fe tc. (Specify)	erm, street, fac	ctory, office		28f. Location (S City or Tow		ber or Rural	Route Number,
within 24 hours effect deeth. To the Funeral Director: Affect thi completely filled in by the funeral Medical Certification: 1										
the Funeral pletely fill	(Check only 2 Medical Ex	hysicien: To the best aminer: On the basis of								
within 24 hours ofter deetl To the Funeral Director: completely filled in by the Medical Certifical	one)	end menner s	tated.		One Lines			20d Data slave	d (Month F	Pau Vass)
¥ C C C C C C C C C C C C C C C C C C C	29b. Signature and title of dertifier	necchia	MO.		29c. Licen	10 02 C	,	29d. Date signe	a a	ray, rear)
	J. Tuck	7			U	14858		0111	11	
	30. Name and address of person wh	o completed cause of	death (Item 23e)	(Type, Print)	s Bos	strate.	#300 F	MUMAP	olis,	Md.
	310001	3000		-101		0			,	
State	31. Date filed (Month, Day, Year)	2. Regist	rar's Signature	1						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 0 8 8 6

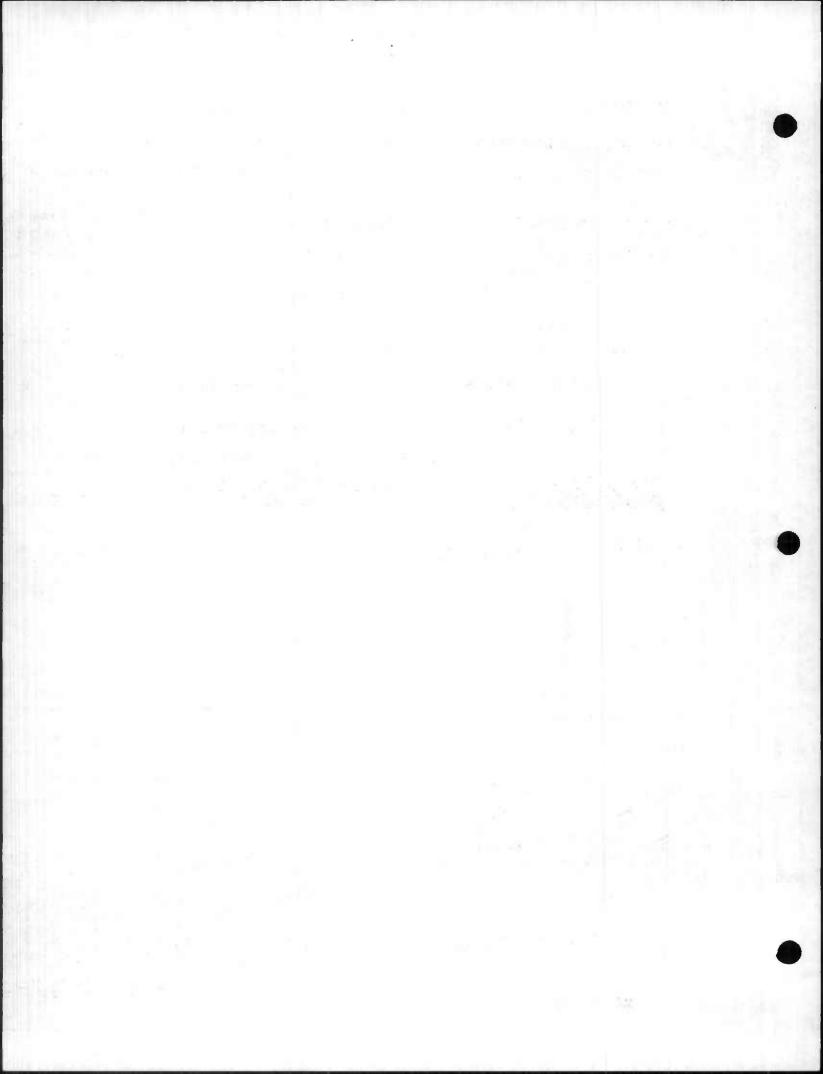
					Ce	rtificate o	f Death		Reg. No.				
Dhua	lalan	1. Decedent's Neme (First, Midd			2110			2. Date of De	eth		. Time of Death		
Phys /Me	ician dicai	PEGGY L	WALKO					March	2. 1999	9 8	:35 A.M.		
Exar		4e. Facility Nama (If not institution	n, giva street and nu	mber)			4b. City, Town, or I						
		Anne Arundel N	ledical Cer	nter			Annapol			e Arund	el		
Funer Direct	_	5. Social Sacurity Number 578–52–6277	6. Sex 1□ M 2只 F	7. Aga (In yrs.	. last birthday) Yrs.	Months Day		8. Date of Bir (Month, De July 26	th y, <i>Year</i>) 5,1929	9. Birthplace Country) Washin	gton, DC		
ryland		Usuel Residence of Decedent 10e. State 10b. Count	1	10c. Ci	ity, Town or Lo	ocation					insida City Limits		
the Marylan 28a-f ehow	cto	Maryland Anne	Arundel			Edgewate	er				1□Yas 2⊠No		
P 2 2	o lo	10e. Street and Number				10f. Zip Code			10g. Citizen of	Whet Country?			
ath w	<u>e</u>	1608 Hilltop F	load				1037			USA			
If I is a within 72 hours after death with the Maryland Hyglans. They have not not then han "natural", or items 23a or 28a-f show ent, the Medical Expenser must be notified at	by Funeral Director	3 ☐ Widowed 4 ☐ Divorce	ried Armed Fo	2XXNo		Was Decedent o If Yes, specify Co 1 ☐ Yes ②○XN	f Hispenic Origin? (S uban, Mexican, Puart o Specify:	pecify Yes or No Rican, etc.)	14. Red Bla Specif	ce - American i ck, White, etc. by: Whit			
Mai yiailia Z. I.Z. 1.5-00.Z.O d.2 should be filed within 72 hours at th and Martal Hyghers T. I. I. marked other than "naturel", or traumatic event, the Med call Expen	Completed	15. Decede (Specify only highe Elementery/Secondery (0-12) 12th	nt's Education est grade completed) College (1	-4or 5+)	(Give	dent's Usual Occ kind of work dor DO NOT use reti Homemak (ne during most of wor ired)	king		usiness/industr	У		
be filed ital Hygid d other			Last)			nomemake	18. Mother's Nan	ne (First Middle					
should be filed withing Mental Hyglana. I marked other than	To Be	0 1	B. Donald	dson				earl Bu					
d 2 should th and Mer 7 ie marks traumatic		19e. informant's Name/Reletion	ship (Type, Print)		19b. Meili	ng Address (Stre	et and Number or Ru	ral Route Numbe	er, City or Town	, Stata, Zip Coo	te)		
of Haalth Item 27		Carl G. Walko		20b. I	Place of Dispo	Hillton esition (Name of matory or other p	Road Edg	ewater,	Marylan 20c. Location	nd 2103 - City or Town,	7 Stata		
Pages nent of int: If it		1 Donation 5 Other (Siare		1 Cemete	d, Mary	land					
permit. Pages 1 and 2 Department of Haalth al Important: If Item 27 ie eny Injury or other trau	9000	21. Signature of Funeral Service	er MD	21037									
Physicia	n	2973 Solomons Island Rd. Edgewater, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
/Medica	at 💮	immediate Cause (Finel disease or condition resulting in deeth)	a. ST	ROKE	-					8	DAYS		
	-	Due to (or as a consequence of):											
ifficata be axecuted g physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	Due to (or as e consec	juence of):							
ifficata be axe g physician as as the burial	Medical	Cause (Disease or injury that Initiated events resulting in death) Last	c	Dua to (or as a consequence of):									
nding use as	N/u		d	-									
daath ce se attand ed for us	sicla	Part il. Other significant conditi	ons contributing to de	ath but not res	sulting in the u	nderiying cause	given in Pert I	23b. Did 1	obacco use co	entribute to the	cause of death?		
requires that the death certificate be associted requires that the death certificate be associated seem signed by the attending physician and should be detached for use as the burial-transit	by Physician/	PERIPHERAL		-							y 4 Unknown		
ls t	Completed	HYPERTENSI	Co						en eutopsy med?	availab	eutopsy findings ala prior to etion of causa h?		
Iclan: Tha is cartificata ha rector, paga	е Соп	Coronned 25. Wes case referred to medica).58A	32		00 Div(D-	101		1 □ Ye	s 2 No		
Physician: this cartific ral director,	To B	exeminer?	11	patient 2	FR/Outpation	at 3□ DOA	26. Place of Dee	th <i>(Check only o</i>		or (Coon't i			
Ing Wher		27. Manner of Death 1 Natural 5 Pendi 2 Accident Invest	28a. Detection (Monte	of Injury h, Day Year)	28b. Time of injury	28c. In		28d. Describe h					
or A fitar Sirec In by	Certification:	3 Suicida 4 Homicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Richtstein) City or Town, State)									ute Number,		
To the Hospital or Atl within 24 hours after of To the Funeral Direct completaly filled in by	edicai (29a. Certifier to Certifyii (Check only one) 2 Medical	ng Physician: To the Examiner: On the ba and mann	sis of examina	occurred et the restigation, in my	rred et the time, date and place, end due to the ceuse(s) and menner as steted. atlon, in my opinion, deeth occurred at the time, dete end plece, and due to the ca				l. cause(s)			
To the To the	Me	29b. Signature and title of certific		MITE	4800		nsa number 39037	1	29d. Date signe	1 -	Year)		
,		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											
		DOUGLAS S					L MEDIC	AL CEA	STER.	ANNAI	BUS MI		

State Registrar

Registrar

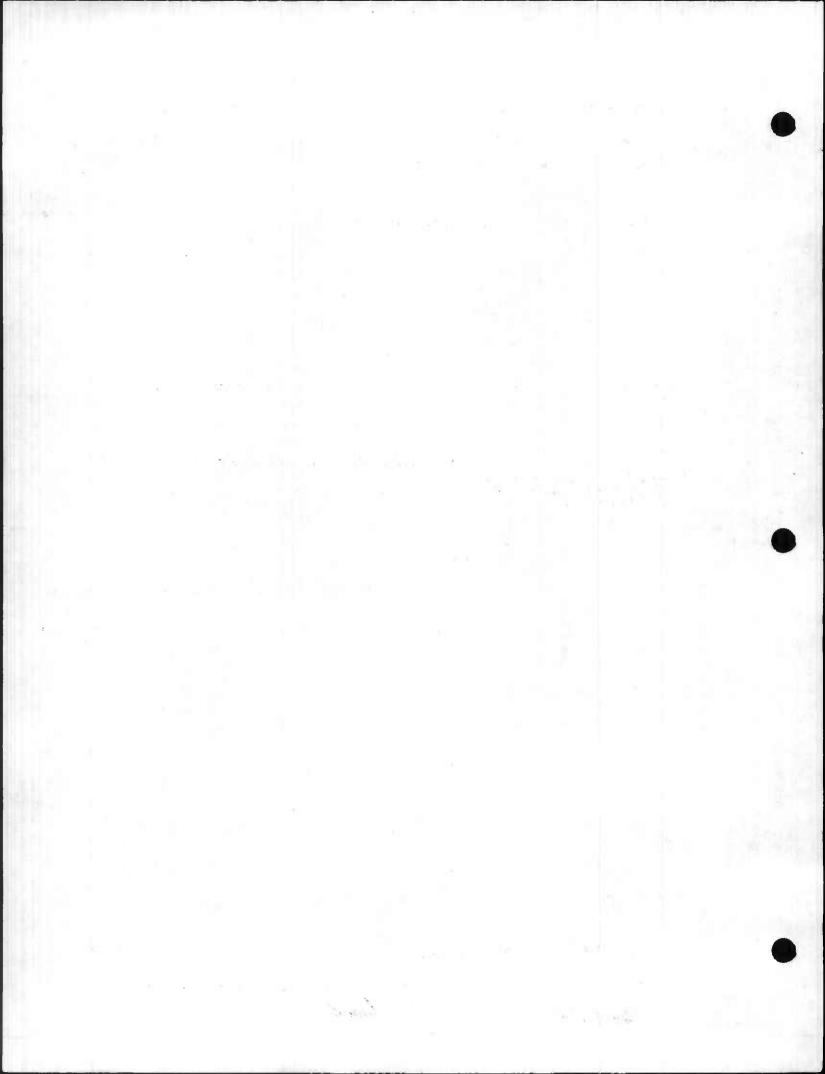
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State of Maryland / Department of Health and Mental Hygiene Q 0 0887

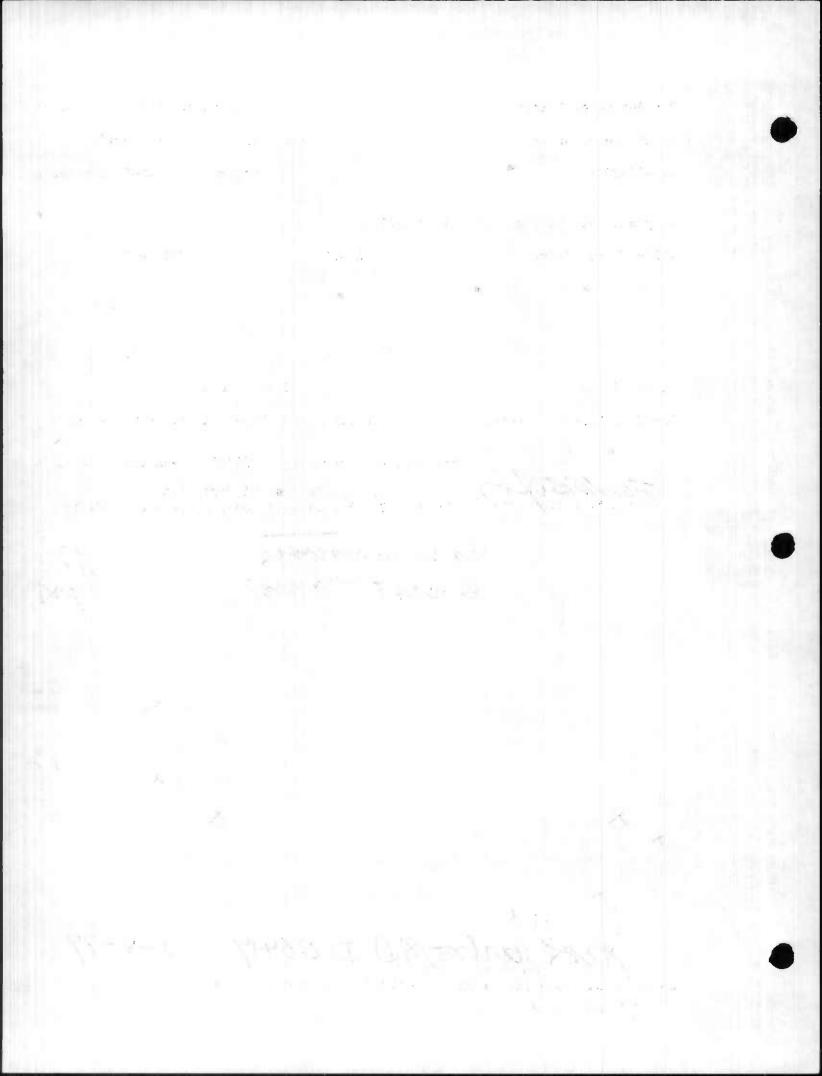
			Certificate of	Death	Reg.	No.		1001
	1. Decedent's Name (First, Middle, La	st)			2. Dete of Death Month	Davi	Value	3. Time of Death
Physician /Medical	John Howard Wa	tson, Jr.			March 2,		Year	11:14
Examiner	4a Facility Name (If not institution, giv	e street and number)		4b. City, Town, or Loc		4c. County of	of Death	
	SHADY GROV	E ADVENTIST H	OSPITAL	ROCKVIL	LE	MONT	rgomi	ERY
Funeral Director	218-86-9223	Sex 7. Age (In yrs. las 30	of birthday) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, You May 15,		9. Birthple Counti Maryl	ace (State or Forei ry) and
1 1.	Usual Residence of Decedent 10a. Slete 10b. County	10c. City, 1	Town or Location				10	d. Inside City Limi
with the Maryland a or 28a-f show the notified at Director	N1 C+ N							1 ☐ Yes 2 📆 I
or 28a-t w be notified Director	Maryland St. Mar	ry s Lexi	ington Park		100	Citizen of W	het Countr	n/2
ter death with the Maylar there 23s or 23s-f show ther must be notified at Furneral Director	20759 Willows Ros	a d	2065	2		nited S		
r thems 23 kiner.must Funeral	11. Marital Stetus	12. Was Decedent Ever in U.S.	13. Was Decedent of H				America	
Example by I	1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates:	If Yes, specify Cub	an, Mexican, Puerto F	Rican, etc.)	Specify:	k, White, e	
ed worm 72 ho rgiene. er then "netur c. the Medical.	15. Decedent's Ed (Specify only highest gra	ducation and completed)	16a. Decedent's Usual Occup	pation	168	. Kind of Bus	siness/Indu	ustry
then the Man	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	d)	<i>'y</i>			
Con Hara	12		N/A			N/A		
B sent	17. Father's Name (First, Middle, Last)			18. Mother's Name				
250 0	John Howard Watso	on, Sr.		Alice C	hristine	Barnes	5	
and Marie	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street	and Number or Rural	l Route Number, C	ity or Town, S	State, Zip (Code)
1 27 mm tr	Alice Watson,		2.0. Box 1567,	Lexington				
or off	20a. Method of Disposition 1 Buriel 2 Cremation 3 C	COM	be of Disposition (Name of netery, cremetory or other ple	ce)	Date 200	c. Location - C	City or Tow	m, State
partment of portaint: If the portaint: If the portaint or o	4 □ Donation 5 □ Other (Specif		culate Heart	of Mary 3/	6/99 Le	xingto	n Par	rk, MD
Depart Import any inj ance	Michael Service Ver	nkenship, M00857	22. Name and Addre Brinsfield	ess of Facility If Funeral l Lywood Road	Home, P.A	A.	MD	20650
	23a. Pert1. Enter the disease, or com shock, or heart tailure. List only	plications that caused the deeth.	Do not enter the mode of dyi	ng, such es cardiac or	r respiratory arrest	d COWIT,		Approximate
nysician	Shock, of fleat tailore. List only	One Cause of each line.						Interval Between Onset and Death
Medical	Immediate Cause (Final disease or condition	Pneumonia					1	2 17001-0
kaminer	resulting in death)	d	s a consequence of):				1	3 Weeks
ةِ السَّادِ			spiratory Fail	ure/Venti	lator Der	andent		3 Years
physician and is the burial-transit edical Examiner	Sequentially list conditions	U. —	s a consequence of):	idee/ vener.	rator bel	, chach		Jiedis
Tale EX	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury		na Multiforme					0 77
physicia as the bur edical	I that writiated events	U.	s a consequence of):					0 Years
5	resulting in death) Last	d		1000				
d by the attendireteched for use	Dadii Oda a laniilaan a a lata				1			
y the	Part II. Other significant conditions of	ontributing to death but not resultii	ng in the underlying cause gi	ren in Part I.		4.0		the cause of dea
d be dete					1 Tes	2)X No	3 Prob	ably 4 ☐ Unkr
been signed by the attending physician and should be detached for use as the butal-transiteted by Physician/Medical Examil					24a. Was an a	utonsv	24h. Wei	re autopsy finding
pege 2 should					performe	d?	com	ilable prior to apletion of cause
m P 2 2							of d	eath?
Com					1 🗆 Yes	2 No	1 🗆	Yes 2□ No
s certificate director, per To Be Co	25. Was case reterred to medical examiner?	Un arrivate		26. Place of Death	(Check only one)			
w .0	1 ☐ Yes 2 No		VOutpatient 3LI DOA		ne 5 Residenc)
h: After ti funera tion:	27. Menner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 26	8b. Time of 28c. Inju	ry at rk?	28d. Describe how	injury occurre	be	
rs after death: al Director: After t led in by the funera Certification:	2 Accident investigation		M 1	Yes 2 No				
d in by the certificat	3 ☐ Sulcide 6 ☐ Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, atreet, factory, office	2	28f. Location (Stree City or Town, S		er or Rurel	Route Number,
Cert Cert								
within 24 hours after death: To the Funeral Director: After thi completely filled in by the funeral Medical Certification:	29a. Certifier Check only one) 2 Medical Exam	ysician: To the best of my knowle niner: On the basis of exemination and manner stated.	edge, death occurred at the tin a and/or investigation, in my o	me, date end place, e ppinion, death occurre	nd due to the caus od at the time, date	e(s) and man and place, a	nner as sta nd due to	ited. the cause(s)
To to to	29b. Signeture end title of certifier		29c. Licens	e number	29d.	Date signed	(Month, D	lay, Year)
	ceeh!	ell m	D3344	13	Ma	arch 2,	, 199	9
	30. Name and address of person who	completed cause of death (Item 23	3a) (Type, Print)					
	Alan R. Pollack,		Mill Road, F	Rockville	Maryland	20851	1	
State	31. Date filed (Month, Day, Year)	32. Registrar's Signature	9//		riar y railt	. 20031		
Registrar	MAR 0 5 199		B. sporks	/				



State of Maryland / Department of Health and Mental Hygiene

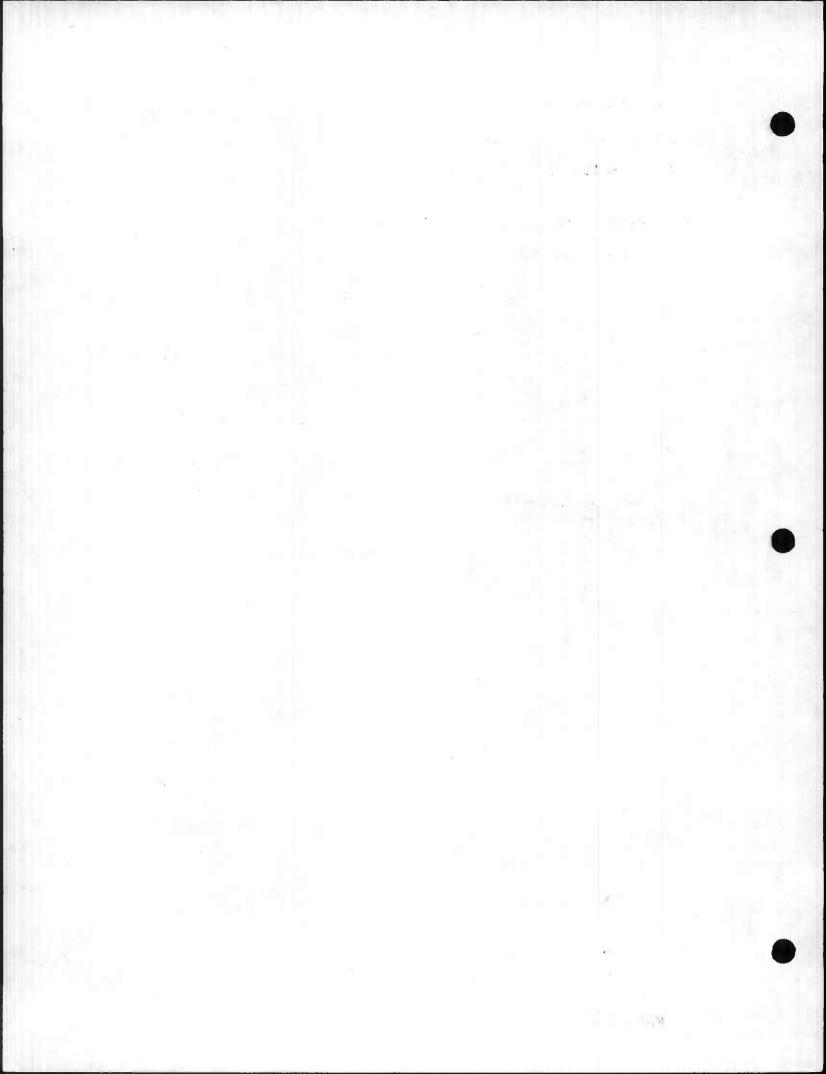
Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** 1999 Dee Ann Carol Warner 1:55 PM March 6, /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 45866 Church Drive Great Mills St. Mary's If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** Days Months 1∏M 2 F Yrs 471-48-2915 53 September 14,1945 Minnesota Director Usuai Rasidence of Decedant permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23s or 28s-f show any Injury or other traumstic event, the Medical Examinat must be notified as anone. 10a, Stata 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yas 2 ■ No Director Maryland St. Mary's Great Mills 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 45866 Church Drive 20634 United States Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ■ No if Yas, Giva 14. Race - Amaricen Indian, 11 Maritai Status Black, Whita, atc. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ■ No Specify: Specify: by 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elementery/Secondary (0-12) Collega (1-4or 5+) Homemaker N/A 18. Mother's Nema (First, Middla, Maidan Sumama) 17. Father's Nama (First, Middle, Last) Donald Yerxa Mildred McLarty 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 45866 Church Drive, Great Mills, Maryland 20634 David A. Warner, Husband 20b. Piace of Disposition (Nama of cematery, crametory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 ☐ Burial 2 ■ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 3/8/99 Alexandria, Virginia 22, Nama and Addrass of Facility 21. Signature of Funeral S. Edward N. Bringfield, Jr. M00052 Brinsfield Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, As shock, or heart failure. List only one cause on each line. **Physician** /Medical immediata Ceusa (Final disaasa or condition rasulting in daath) Examiner Examiner physician end the bunal-trensit lew requires that the death certificate be executed Sequantially list conditions, if any, laeding to Immadiata ceuse. Enter Undarlying Cause (Disaasa or injury that initiated avants resulting in death) Last Dua to (or as a consequance of) Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequance of): 80 950 ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed l þ 24b. Wara autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy parformed? Completed peeu NA 20 No. page 2 1 Yas 2 No 1 Yes certificate or Attending Physician: director. 25. Was cesa rafarrad to medicel Be 26. Piaca of Daath (Chack only ona) axaminar? Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2No 2 1 Inpatiant 2 ER/Outpatient 3 DOA After this funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred Certification: 28b. Tima of 28c. Injury at Work? 1 Naturai 2 Accidant 5 Panding invastigation injury efter deeth. Director: Aft 1 Yas 2 No 6 Could not be 3 Sulcida 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours Hospital Certifying Physician: To the best of my knowledge, daath occurred at the time, date and place, and dua to tha causa(s) and manner as stated.

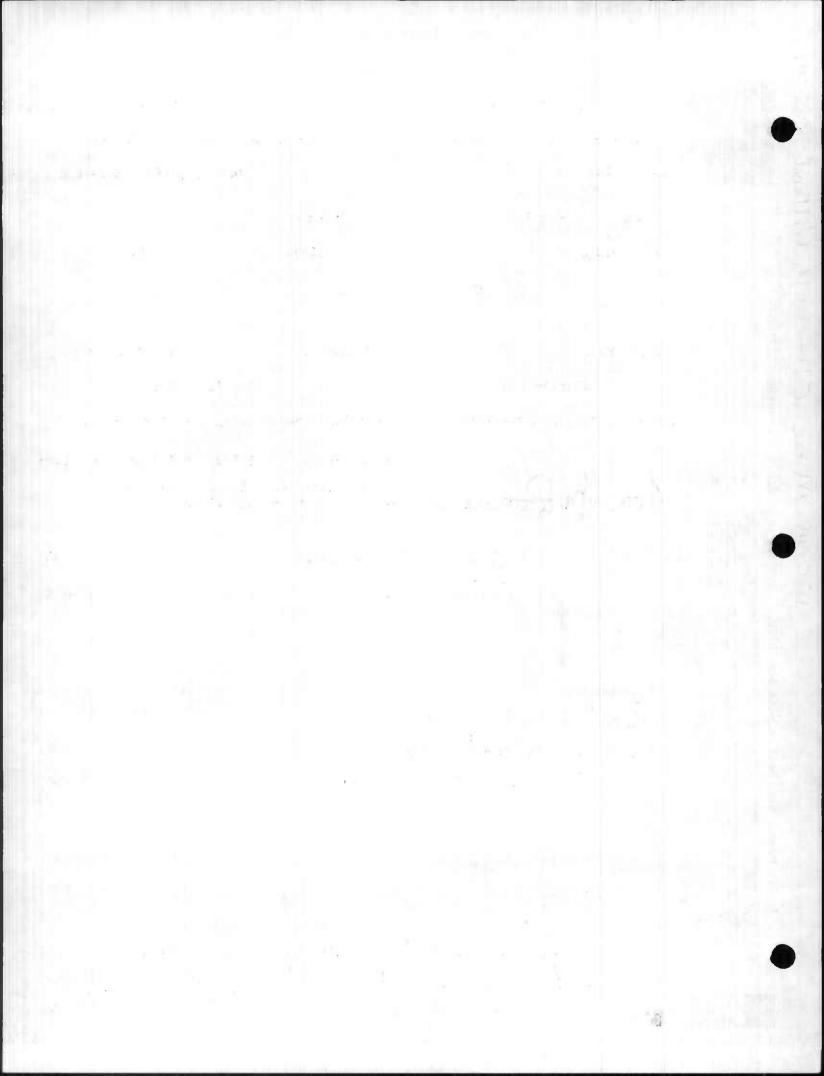
Medicat Examinar: On the basis of examination end/or investigation, in my opinion, daath occurred at tha time, data and place, and dua to tha causa(s) and manner stated. Medical 29e. Certifian completely To the Vithin 2 29d. Data signad (Month, Day, Year) 29b. Signatura ar 29c. Licansa number of certifier eted causa of daath (Itam 23a) (Type, Print) parson who 30. Nama and ago Jarboe, P M.D. 24035 Three Notch Road, Hollywood, Maryland 20636 James 32. Ragiafrar's Signatura 31. Data filed (Ma State 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene

			(Certifica	e of	Death	F	Reg. No.	U	0003
4	1. Decedent's Neme (First, Middle, Last)					2. Date of Des Month	ith	Year	3. Time of Death
Physician /Medical	John Albert We	bster					March 3	, 1999	1 ear	4:00 a
Examiner	4e Facility Name (If not institution, give	street and number)				4b. City, Town, or	Location of Death	4c. County o	f Death	
	719 Girard St., I		ice, MI)		Havre de		Harfo		
Funeral Director		714 000	yrs. last birth	day) If Unde Months	Days	If Under 24 Hrs Hours Min.	8. Data of Birth (Month, Day April	7 Year) 23,1928	9. Birthpl Count Ma	ace (State or Forei ry) ryland
pu a	Usual Residence of Decedent 10a. Stete 10b. County	1100	c. City, Town	or Location					140	d. Inside City Limit
the Merylan 28a-f ahow notified at										1 StYes 2 □ N
28e-f notifie	Maryland Harf	ord	Hav:	re de	Gra	ce		log. Citizen of Wi	hal Cause	
23e or	719 Girard Str	eet	in a		107	8		US	iat Count	ny r
Hems Description	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U,S.	13. Was Dece	dent of h	lispanic Origin? (S an, Mexican, Puer	specify Yas or No- to Rican, etc.)	14. Race Bleck	 America Whita, e 	
ours efter Execute I by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	1 □ Yas 2 No If Yas, Giva Year or Dates:	- 7.			Specify:	18-31	Specify:	- 7	
"natural", dra E.	15. Decedent's Edu (Specify only highest grad		16a. C	ecedent's Usu	al Occup	pation during most of wo	rkina	16b. Kind of Bus	inass/Ind	ustry
nith na	Elementary/Secondary (0-12)	College (1-4or 5+)	- '	o bo word chani	se retire	d)		Automo	+ 1 374	
e filed wi other th vent, the	17. Fethar's Neme (First, Middle, Last)					18. Mother's Na	me (First, Middle,			
Mentel H Mertel H arked out attc even	unkno	wn				There	sa Webs	ster		
ges 1 and 2 should be filed it of Heelth and Mental Hyg If I fem 27 is marked other or other traumatic event,	19e. informent's Neme/Retetionship (T)	roe. Print)	19b. I	Aailing Addres	s (Street	and Number or Ri			tete. Zio	Code)
ther Trau	Martha Allen /	sister				, Kansa				
other t	20e. Method of Disposition	2	Ob. Place of D	isposition (Na	me of	1		20c. Location - C	ity or Tox	wn, Stete
Peges ment of ant: If It ury or o	Wall Buriel 2 □ Crametion 3 □ F 4 □ Donetion 5 □ Other (Specify)	Removal from State		ames C	hur	ch Cem	3/11/9) Havre	de	Grace,
permit. Pege Department of Important: If any Injury or once.	21. Signature of Funaral Service Licens	66				ss of Facility B				
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To the Hospital or Attending Physicien: The is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	2 Accident investigation 3 Suicide 6 Could not be determined	281. Location (S City or Tow	itreet end Numbe n, Stete)	r or Rure	Route Number,					
To the Hospital within 24 hours within 24 hours to the Funerel completely filled		sician: To the best of my ner: On the basis of examend manner stated.								
Me Within	29b. Signatura and title of certifier			29	c. Licens	se number		29d. Date signed	(Month, I	Day, Year)
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1	20 Name and address 4	months and annual of the side	(Nom 22-) (T	ma Pint	P M	1020 DA	16			
6	30. Name and addrass of person who co	nion TV	(trem 23a) (T	pe, Print) 1	K. M.	e De	Gra	ce, 1	ND	2107
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State of Maryland / Department of Health and Mental Hygiene Q 0 0 1

					Certifica	te of D	eath	R	eg. No.	0.0	091				
		1. Decedent's Name (First, Middle,	Last)					2. Dete of Deel Month	h Dey	Yeer	3. Time of Death				
-	Physician /Medical	veronica r	. Wr:	ight				March 2		1001	1:35 am				
	Examine	An Physician blomm of the and to add the	give street and number)		4b.	City, Town, or Lo	cation of Deeth	4c. County	of Deeth					
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	Funeral			ge (In yrs. last bir		er 1 Year	If Under 24 Hrs.	8. Dete of Birth			ece (Stete or Foreign				
	Director	157-12-3291 Usuel Residence of Decedent	1□ M 2∏ F	81	Yrs. Months	s Deys	Hours Min.	Feb. 15			Jersey				
	anyland anyland	10e. Stete 10b. County		10c. City, Tow	n or Location					10	d. Inside City Limits				
	W THE	Maryland Prince	George's	Нуа	ttsvill	e					1A 168 2 140				
	or 28a-t	10e. Street and Number			10f. Z	ip Code		1	0g. Citizen of V	/het Countr	у?				
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21215-0020	n 72 hours after death with the Maryland "natural", or flems 23s or 28s-f show edical Examiner must be notified at	11. Maritel Status 1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 Tyes 2X ff Yes, Give Yeer or Detes:	?	1000	edent of Hisp ecify Cuben, 2X No	penic Origin? (Spe Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)		America k, White, et	tc.				
ŏ	hou			16e.	Decedent's Us	uel Occupation	on		16b. Kind of Bu						
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	EIDE a		ast)			1	8. Mother's Name	(First, Middle, I	Meiden Sumem	e)					
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2	and Menta	19e. Informent's Name/Reletionshi			. Meiling Addre	ss (Street en	d Number or Rura		. City or Town.	Stete, Zip (Code)				
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o,	f Health tem 27 I	Judy Ryland - Da	ugnter	20b. Plece of	Disposition (N	eme of			20c. Location						
ğ	8 5 5	1 XBurial 2 ☐ Cremation		cemeter	y, cremetory or	other piece)									
	Imer Innt:	4 Donetion 5 Other (Specify) George Washington Cemetery 03/05/99 Adelphi, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility													
Baltimore,	Department of Important: If any injury or once.	22. Name and Address of Fecility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781													
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		23e. Part1. Enter the disease, or o shock, or heert failure. List o	nly one ceuse on each	ine.	iot office the file	oco or cynig,	000000000000000000000000000000000000000	. roop a orony on	001,		Intervel Between Onset end Deeth				
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	0	TERRY JODRIE	, M.D., PRI	NCE 6				VIER, C	HEVER	64, n	MARYLAND				
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State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth March 3, **Physician** 5:05 PM Nancy S. Williams /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3101 Cheverly Ave. Cheverly Prince Georges 8. Date of Birth (Month, Day, Year) July 9, 1936 If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 10 M 20 F Days Hours Months Washington, D.C. 219-34-7733 62 Yrs. Director Usuel Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or liams 23s or 28s-f show the Medical Examiner must be notified at 1XXYes 2 No Prince Georges Chever1v Maryland Directo 10e. Street and Number 10f. Zip Code 10c. Citizen of What Country? death with 3101 Cheverly Ave. 20785 USA Funeral 13. Was Decedent of Hispanic Orlgln? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑No If Yes, Give 1 Never Married 3 Married Baltimore, Maryland 21215-0020 1 Yes 2€XNo Specify: Specify: à White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 years
17. Fether's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Haath and Mental Hy Important: if Itam 27 is marked othe any Injury or other traumatic event page. 18. Mother's Name (First, Middle, Maiden Sumame) Be Simon Severns Mary A. Mayer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gray L. Williams - Spouse 3101 Cheverly Dr., Cheverly, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State March Ft. Lincoln Donation 5 Other (Specify) 6, 1999 Brentwood, MD 21. Signatu e of Funeral Service 22, Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finei BREAST CHUCER disease or condition resulting in deeth) Examiner Examiner physicien and s the buriel-transit that the deeth certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): P.O. Box 68760, Physician/Medical Due to (or as a consequence of): attending phy d for use as t the t Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, à law requires 24b. Were autopsy findings available prior to completion of cause of death? should l 24a. Was an autopsy Completed i cartificata has t firector, page 2 s 1 Yes 2 No 1 Yes 2 No Hospital or Attanding Physician: 24 hours aftar death. Funeral Director: Aftar this carifics director, 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 5 Pending Investigation 1 Natural 1 Tyes 2 □ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 6 4 Homicide C To the Hospital or within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier cus 018219 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) TIBOHEN STAME 1221 WEREAUTICE MARRO, CANE 31. Date filed (Month, Day, Year)
MAR 0 5 1999 2. Registrer's Signature

DHMH 16 Rev 6/95

Registrar

15 M.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 2:50 Am L. 1/160 hat son Murch /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Lorien Nursing & Rehabilitation Center Columbia Howard 6. Sax 1 → M 2 □ F If Under 1 Year Months Days If Under 24 Hrs. 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours 75 North Carolina **Director**

Director

Funeral

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Completed

Be

the Maryland r than "natural", or hems 23s or 28s-f show the Wadical Examiner must be notified at death filed within 72 hours after Hygiene. Wher then "netural", or ite

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: if tem 27 is marked other that any Injury or other traumatic event, that page.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

> physician and s the burial-transit for use as 9SI

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Division of Vital Records, P.O. Box 68760,

577-28-3479 Usual Rasidence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Mary land Prince George's Lanham 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 20706 9785 Good Luck Road, Apt #6 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Evar in U.S. Armed Forcas? 11 Maritel Stetus 1 Never Married 2 Married 1 X Yas 2 No If Yas, Giva Specify: Black 1 Yes 2 No Specify: 3 Midowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementary/Secondary (0-12) Collega (1-4or 5+) Government Mail Carrier 12th 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surname) John C. Watson Elnora Cherry 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 9785 Good Luck Road, #6, Lanham, Maryland 20706 Robin Green-Calloway/Daugher 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 03709 1 Burial 2 □ Cramation 3 □ Removel from Stete Maryland Veterans Ceme. Cheltenham, Maryland 1999 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvice Licensee J. B. JENKINS FUNERAL HOME Perce 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediata Causa (Final Stroke diseasa or condition rasulting in death)

1 Yes 2 No

Approximata Interval Between Onset and Death

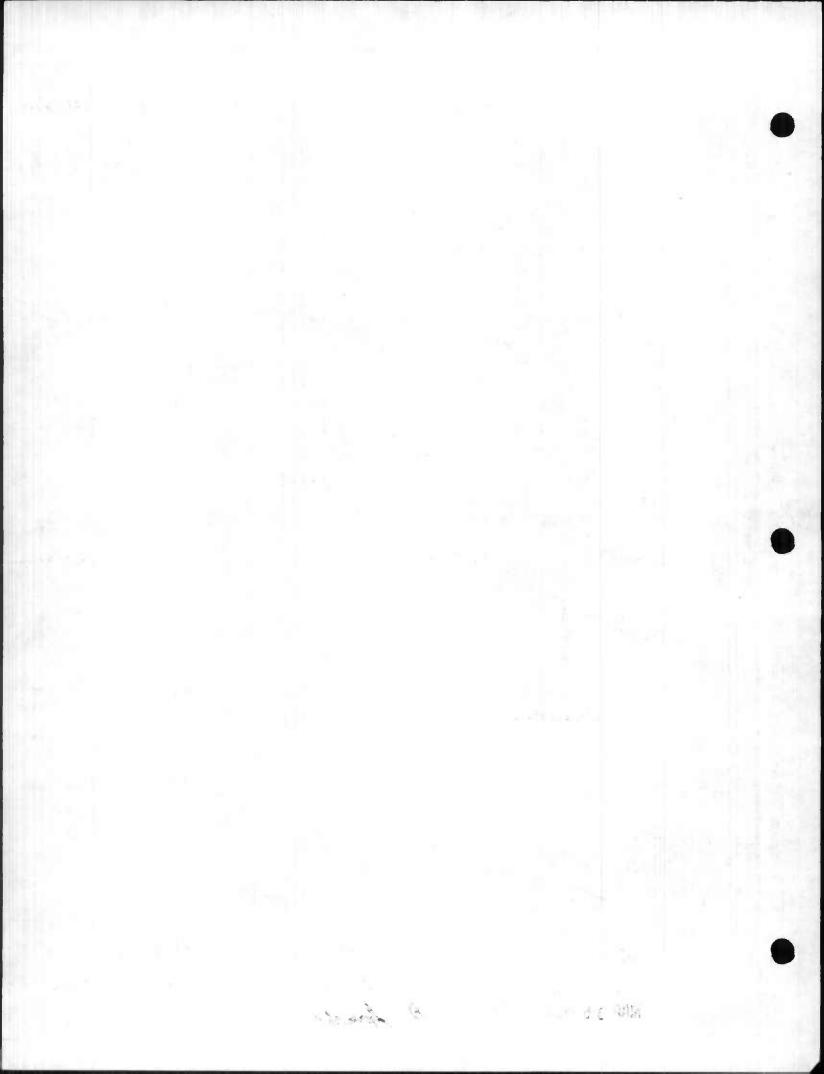
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					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
					1 Yes 2 No	1 Yes 2 No
25. Was case ratarred to medical axaminar?				26. Place of	Death (Check only one)	
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27. Mannar of Death 1 Natural 5 Pending 2 Accidant invastigs	ition	Data of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occu	irred
3 Suicida 6 Could no datarmin		Place of Injury - At h building, atc. (Special	ome, farm, street, fact	ory, office	28f. Location (Street and Num City or Town, State)	ber or Rural Routa Number,
	xaminar: On				ace, and due to the cause(s) and m occurred at the time, data and place	
20h Sanature and title of certifiers				29c License number	20d Data sign	ed (Month Day Year)

State Registrar

(Month, Day, Year, 11251 32 Registrar's Signatura MAR 0 5 1999

d cause of death (Item 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day **Physician** LILLIAN WILLIAMS 2 March 1999 6:35 AM /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 7877 Burnside Road Prince George's Landover If Undar 24 Hrs. 5. Social Sacurity Number if Under 1 Year 8. Data of Birth (Month, Day, March 18, 9. Birthpleca (Stete or Foreign 7. Aga (In vrs. last birthday) **Funeral** 1 M 2 F Months Days Hours Min 242-46-2806 84 Yrs. North Carolina Director Usuel Rasidanca of Decadant the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 X Yas 2 □ No Maryland Prince George's Landover Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with than "natural", or items 23s or the Medical Examiner must be 7877 Burnside Road 20785 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours aftar death ant of Health and Mental Hygiena. 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ≦ No If Yas, Giva Yaar or Datas: Was Decedant of Hispenic Origin? (Specify Yes or No-It Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Reca - American Indian, Black, Whita, atc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: by 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b Kind of Business/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) Housekeeper Private 11th 18. Mothar's Nama (First, Middle, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Fannie Burt Grier Harris 19b. Mailing Address (Straat and Numbar or Rural Routa Number, City or Town, Steta, Zip Code) 19a. Informant's Nama/Ralationship (Type, Print) nt of Haalth a: If Item 27 is Barbara Devese/Daughter 6303 Southern Avenue, Capitol Heights, MD 20743 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 03706 1999 1 2 Burial 2 Cremetion 3 Ramovel from Stata permit. Page Department of fmportant: If any Injury or Harmony Memorial Park Landover, Maryland 4 ☐ Donation 5 ☐ Other (Spacify) 21. Signatura of Funaral Sarvice Licensea J. B. JENKINS FUNERAL HOME N le 7474 Landover Road, Landover, Maryland 20785 ance 23a. Part1. Enter the disees , or complications that caused the death. Do not anter the mode of dying, such es cardiac or respiretory errest, shock, or heart tallium. List only one cause on each line. Approximata Intarval Between Onsat end Death Physician ardiovesador b /Medical Immediata Cause (Final disaasa or condition resulting in deeth) Examiner Examiner requires that the death certificate be asscuted physician and the burial-transit Sequantially list conditions, if any, laading to immediate ceusa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequanca of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown dypour hi by 24b. Wara autopsy tindings available prior to complation of cause of death? Completed 24a. Was an autopsy performed? 20 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only ona) Hospital or Attending Physician: funeral director, 25. Was cesa ratarrad to medical examinar? Be Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4□ Nursing Homa 5 ☐ Hasidance 6 □ Othar (Specify) 1 Yes 2310 Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Mannar of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 1 Naturel 5 Pending after death. Director: Aft 1 Yas 2 No invastigation 2 Accident 6 Could not be datamined 3 Suicida 28t. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homicida 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d. Deta signed (Month, Day, Year) 29b. Signature and title of partition 29c. License number 30. Nama and addrass of person who completed cause of death (itam 23a) (Type, Print) andover f CLAMOR YES or, D 31. Data tiled (Month, Day, Yaar) 32 Registrer's Signature

DHMH 16 Rev 6/95

Registrar

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	State of Maryland / Department of Health and Mental Hygiene
	Constitute of Booth

	Physician /Medical	D #1 P.G 1. Decedant's Na DENIS	me (First, Middle, MART	Last)	KINS				2. Date of De- Month Feb .	Day	Yaar 999 10:48pm	
	Examiner	4a Facility Name		give street end num				4b. City, Town,	or Location of Death	4c. County	of Deeth	
		PRINC	PRINCE GEORGES HOSPITAL CENTER						LY	PRIN	CE GEORGES	
П	Funeral Director	5. Social Security 577–74		Sex 1□M 25F	7. Age (In yrs. Id 4 (If Under 1 Ye Months Day			y, Year)	9. Birthpleca (State or Foreign Country) Washington D	
L	9	Usual Residence	of Dacedent						05.00	1.3.42		
	Maryland of show	10a. State	10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits 1 ¥ Yas 2 □ No	
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ter death Items 23	s 23a	6604	6604 GREIG ST #101					0743			USA	
	er de	11. Marital Status		Armed For	1 ☐ Yas 252 No		Yas, specify C	uban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	Bian	ace - American Indian, iack, White, etc.	
	8 05		rriad 2 Married 4 X Divorced	If Yes, Give			1 Yes 2 No Specify:			Specify		
	natural', ara Eu		15. Decedent's		103.	16a, Deced	ent's Usuel Oc	Occupation		Black 16b. Kind of Business/Industry		
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212	filed within 72 ho Hygiene. ther than "naturi ont, me weden!	1	_	College (1-	401 3+)	Hote	el Res	ervatio	ns Mgr.	Hosp	itality	
פ	al Hygid d other event, the Be Co		e (First, Middle, La	st)					lame (First, Middle,			
Marylai nd 2 should b uth and Ments 27 Is merked r traumetic e	Menta Menta Prikad To E		L. Atk	inson				Evely	n Marie	Banks		
	a ma		Name/Relationship	(Type, Print)		19b. Mailin	g Address (Stre	eet and Number or	Rurel Route Number	er, City or Town,	Stefe, Zip Code) 20743	
	and salth	Ms. Sh	awnise	Young/D	aughte	r 660	04 Gre	ig St.	# 101 C	apitol	Hgts.,Md	
ore	ges 1 and t of Health If item 27 or other to	20a. Method of D	•	□Ramoval from S	06	ece of Dispos metery, crem	sition (Neme of netory or other)	plece)	Dete	20c. Location	- City or Town, State	
E	8 5 4 7		5 ☐Other (Spe			ntt C	remato	ry	2/22/99	Waldorf,	Maryland	
Baltimore,	permit. Pa Departmen Important: any Injury ance.	21. Signature of	Funeral Service Lic	ensee	1.4			dress of Facility	1 II-	T	20746	
0	82559	Monga	Moritan	meiz-Ch	athan	- 4	edar fi 111 Pe	nnsylva	eral Ho	me Inc . Suit	iand, Md	
		23a. Pert1. Ente	r the disease, or co	emplications that ca	used the death	. Do not ente	er the mode of	dying, such es card	liac or respiratory a	rrast,	Approximete Interval Between	
P	hysician			.,							Onset end Death	
100	/Medical	Immediate Caus disease or condi	tion	. ,	Pulmon	1 1/2/	Ē m	Anlas			M5 min	
	Examiner	resulting in death	1)	a	Due to (or	as e conseq	uenca of):	701-7				
	in in			- b	Deco	YE	w 3	hrom 30	52 5			
	be executed fician and burtal-transit	Sequentially list	conditions,	U		es e conseq						
68760, ficate be exect physician and is the burial-tra	cian cian ourial	Sequentially list if any, leading to cause. Enter Un Cause (Disease	derlying or injury	c	Throm 80 by To Denia						1 7	
68760,	physician s the buria	that initiated events resulting in death) Last Dua to (or as e consequanca of):										
	ding p			d	Lu	pus						
Вох	death certified at the standing of for use a					7						
P.O.	the de ached ached	Pert II. Other sign	nificant conditions	contributing to dea	ath but not resu	ilting in the ur	nderlying cause	given in Part I.			ontribute to the ceuse of death'	
	ed by detac	GAS	stre Ini	47+ WA1	Grazo	1. N 07			10	Yes 2□No	3 Probably 4 ₫ Unknow	
	The law requires that the death certinate has been signed by the attending page 2 should be detached for use a Completed by Physiclan/M								24a. Wes	an autopsy	24b. Were autopsy findings	
Ö	been shou	Se	vere	Anemia		I	Ferior	MYOL	NET DON	rmed?	available prior to completion of cause	
cord	has the page 2 s				,			INFA			of death?	
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al Record	icate ha		erred to medical	Hospital:				Other:	Deeth (Check only o		(0	
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of Vital Rec	Physician: this certifical director	25. Was case ref	1	1 Kil					28d. Describe	how injury occur		
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State Registrar

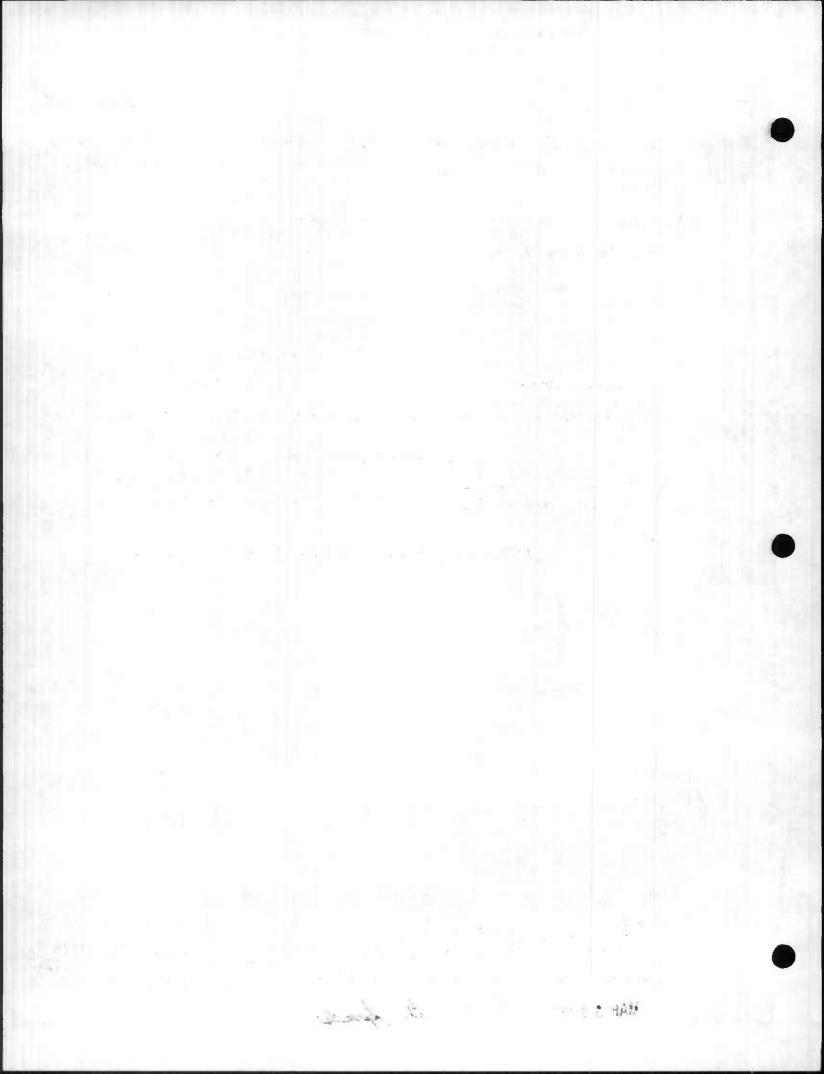
31. Dete filed (Month, Dey, Year) FEB 2 2 1999

32. Registrer's Signeture.

State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** 0422 Herbert H. Wright 02 MARCH /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** PRINCE GEORGES GEORGE'S CHEVERLY HOSPITAL CENTER PLINCE If Under 1 Year Months Days if Under 24 Hrs. 8. Dete of Birth (Month, Day Ye Oct. 20, 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign Country) North Carolina 6. Sex **Funeral** 1930 1 M 2□ F Hours 470-34-6732 68 Director Usual Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23s or 28s-f short the Medical Examiner must be notified at 1 Ves 2 □ No Maryland Prince George's Capitol Heights Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20743 6415 Cabin Branch Ct. United States Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 △ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Maritel Status filed within 72 hours efter 1 Never Married 2 Married Black Ballimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: P 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Electrical Engineer Government 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Father's Neme (First, Middle, Last) Pages 1 and 2 should be fill ment of Health end Mentel H Be Edna Goode Raymond Wright 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Tawanna Chesley - Daughter 18515 Strawberry Knoll Rd., Gaithersburg, MD 20879 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removel from State 6 then! Maryland Veterans Cem. 3/10/99 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signatura of Funeral Service Licensee Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, lock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Final CARDIOVASCULAR DISEASE diseese or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner buriel-transit end Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): physician P.O. Box 68760 certificate be Physician/Medical the Due to (or as a consequence of) 98 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t Records, Completed by 24b. Were eutopsy findings eveilable prior to 24e. Was en eutopsy performed? peen completion of ceuse of deeth? page 2 2 No 1 Yes 1 ☐ Yes 2 ☐ No certificete Division of Vital director 25. Was cese referred to medical Be 26. Piece of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Deeth 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Certification: After 1 Naturel 5 Pending investigation death. 1 Yes 2 No or Attendation of the order of 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) in by 4 ☐ Homicide 24 hours Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and piece, and due to the ceuse(s) end menner es stated. Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end piece, end due to the ceuse(s) To the To the To the I 29b. Signature 29d, Date signed (Month, Dev. Year) (Type, Print)

State Registra (Month, Day, Year) MAR 0 4 1999

32/Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** Robert Ear1 Warwick February 28, 1999 2:59pm. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Doctors Community Hospital Lanham Prince George's Co. If Under 1 Year If Undar 24 Hrs. 8. Deta of Birth (Month, Dey, Year) 5. Social Security Number 7. Aga (In yrs. lest birthday) Birthpleca (Steta or Foreign Country) **Funeral** 10 M 2□ F Yrs. Director 108-22-2336 March 20, 1931 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 7 is marked other than "natural", or itsms 23a or 28a-f show traumatic event, the Medical Examination must be notiled at 10d. Inside City Limits 1 X Yes 2 □ No Director Maryland Prince George's Hyattsville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5825 32nd Avenue 20782 U.S.A. 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Yeer or Detas: KOREAN Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indien, Black, Whita, etc. 11 Marital Status 1 Naver Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filled with Department of Health and Mentel hygient important: if them 27 is marked other the any Injury or other trauments 12 Statistical Supervisor U.S. Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) George Francis Warwick Mildred M. Thompson 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Sylvia Warwick - Wife 5825 32nd Avenue, Hyattsville, Maryland 20782 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 N Buriel 2 □ Crametion 3 □ Removel from Stete 4 □ Donetion 5 □ Other (Specify) Maryland Veterans Cemetery 03/05/99 Cheltenham, Maryland 21. Signature of Funerel Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximeta Intarval Between Onsat and Deeth **Physician** /Medicai Immediate Ceuse (Final disease or condition resulting in deeth) Examiner be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Diseese or injury that initieted events resulting in deeth) Lest physician end s the buriel-tran Box 68760, phylem Physician/Medical bue to (or en e consequence of): for use as P.O. 1 Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Assase 1 Yes 2 No 3 Probably 4 ☐ Unknown signed b Records, þ Completed 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? page certificate 1 Tyes 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yes 2N No 1) Inpatiant 2□ ER/Outpetient 3□ DOA this funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) Certification: 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Attending Affer Division 5 Pending Investigation 1 Naturel 2 ☐ Accident To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun. 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide edical 29a. Certifier Certifying Phyeician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the cause(s) and menner statad. (Check only 29d. Data signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. Licansa number D 21883 ANDA POLIS Rd. SUITE #308 who completed cause of deeth (Item 23a) (Type, Print) 9470 M.D. 92. Registrer's Signeture State Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Daeth 3. Time of Death Month **Physician** Gordon Page Williams February 23, 1999 12:20 p.m. /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Prince George County Hospital Cheverly Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | July 19, 1908 5. Sociel Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** 1₽M 2□F Connecticut 90 123-10-7040 Director Usuel Residence of Decedent 10d. Inside City Limits 10a. Stete 10c. City. Town or Location the Marylen 10b. County r than "natural", or itams 23a or 28a-f ahow the Medical Examiner must be notified at Prince George's Mitchellville MD X Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20721 10450 Lottsford Road #105 Funeral death 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No ₩₩ II If Yes, Give 14. Raca - American Indien, 11 Maritel Stetus Black White etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16e. Decedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry International Monetary Hygiene. Elamantary/Secondary (0-12) College (1-4or 5+) Fund 6+ Economist and Mental Hygical In marked other 18. Mothar's Nema (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) nit. Peges 1 and 2 should be flit entment of Health and Mental Hy ortant: If Item 27 Is marked oth Injury or other traumatic even Roger H. Williams Frances Coleman 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Anne Paley - Daughter 12 Sharon Station Road Sharon, CT 20b. Place of Disposition (Name of cametery, crematory or other plece) 20e. Method of Disposition Deta 20c. Location - City or Town, Stete 1 ☐ Buriel 2 Cremetion 3 ☐ Removel from State 3/1/99 Laurel. Maryland Balt.-Wash. Crematory 4 Donetion 5 Other (Specify) 22. Name end Address of Fecility Joseph Gawler's Sons 21. Signeture of Funerel Service Licensee 5130 Wisconsin Ave. N.W. Washington, D.C. 20016 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximeta Intervel Batween Onset end Death **Physician** Aupiration Preumanie /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Corchiol Inforction week requires that the death certificate be executed physicien and the buriel-tran Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Causa (Disaese or Injury that initieted events resulting in daath) Lest Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or es e consequenca of) USB 0 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ed by the 1 Yee 2 No 3 Probably 4 Unknown anotonol Hamadone signed t A Records, 24b. Wara autopsy findings eveilabla prior to completion of cause of daeth? Read Facture 24a. Was en eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No. certificate Division of Vital 25. Wes case referred to medical Be 26. Pleca of Death (Check only one) Hospital: 1 Pinpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Lo this 28e. Dete of Injury (Month, Dey Yeer) 28c. Injury et Work? 27. Menney of Deeth 28b. Time of 28d. Describe how injury occurred Certification: or Attending Peter death. 1 PNeturel 5 Pending 1 ☐ Yas 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be datarmined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28a. Placa of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 4 T Homicida 24 hours Hospital 1 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stetad. edical 29a. Certifier (Check only one) within 2 To the 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of cartifier 29c. License number

State Registrar

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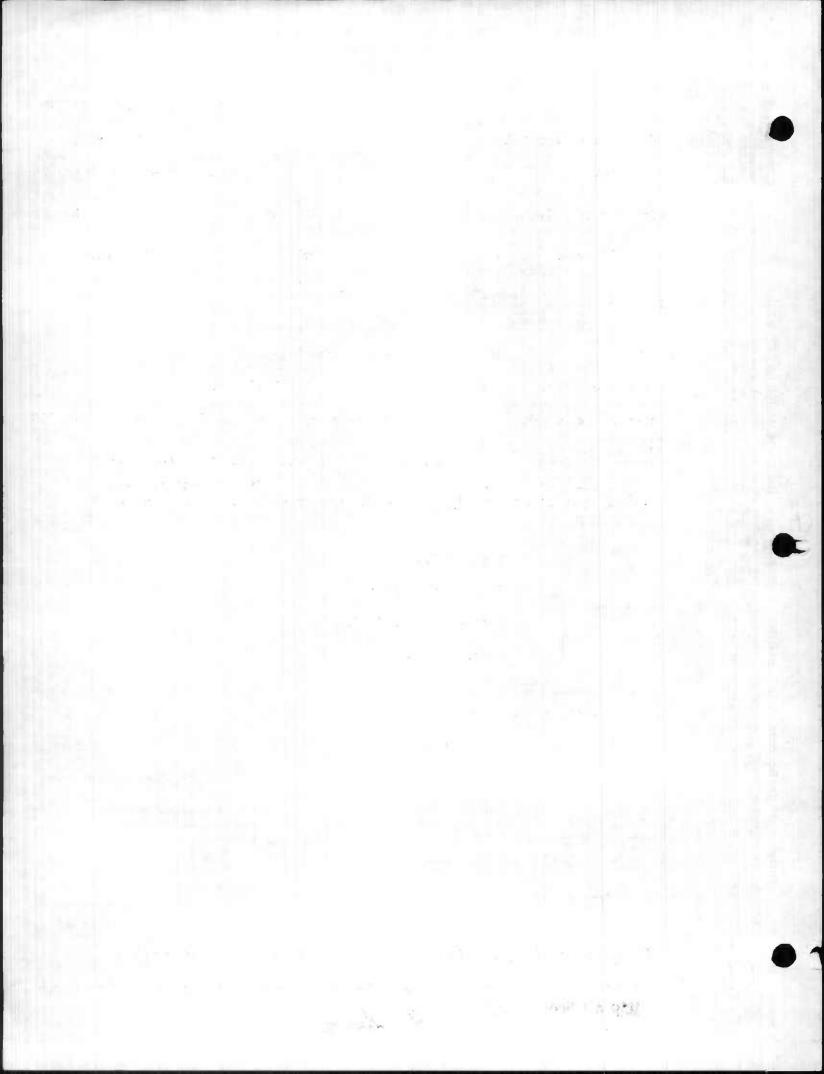
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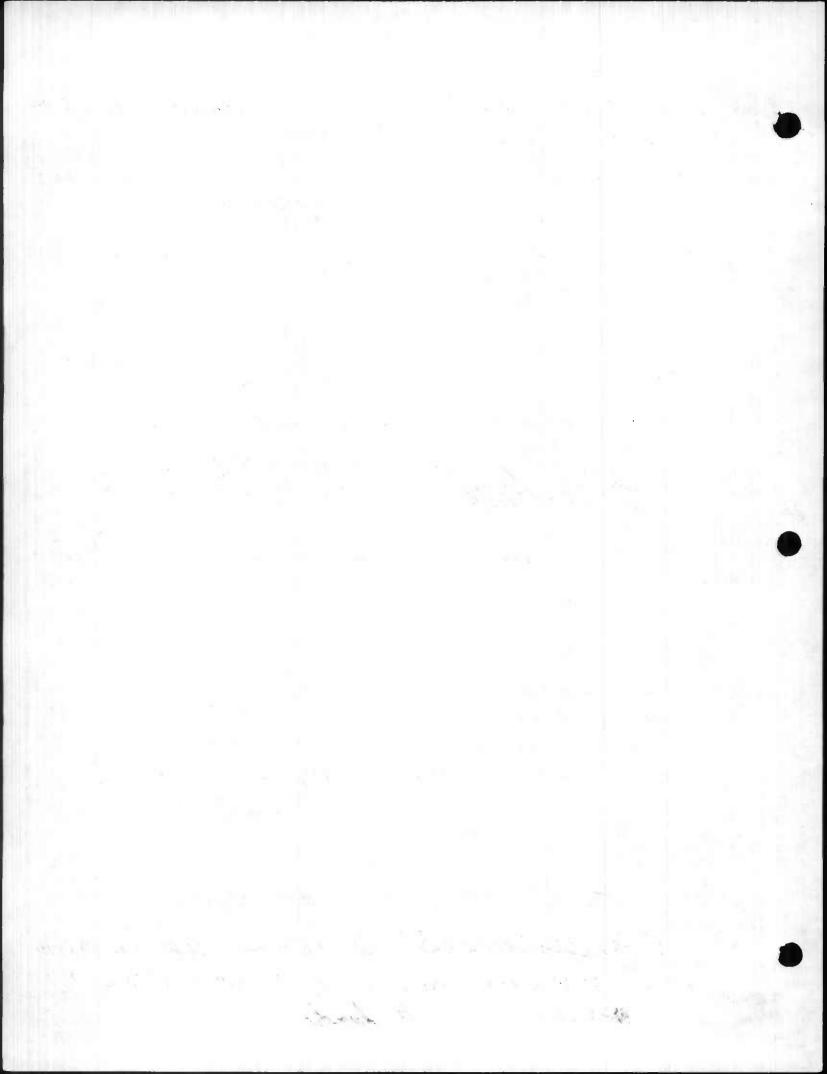
		Department of Health and I Certificate of Death	Reg. No.	08899					
Physician · /Medical	1. Decedent's Name (First, Middle, Last) Betty W. Wirt	2. Dete of Deeth Month Dey Feb. 23	Year 1999 5:05PM						
Examiner	4a Facility Neme (If not institution, give street and number)	4b. City, Town, or							
Funeral	Holy Cross Hospital 5. Social Security Number 6. Sex 1 M 2 X F 7. Age (In yrs. lest birth	Months Devs Hours Min.	8. Date of Birth (Month, Dev. Year)	ntgomery 9. Birthplece (State or Foreign Country)					
Director	Usuel Residence of Decedent	frs.	Apr. 23 1928	South Carolin					
death with the Meryland ms 23a or 28a-f show Linuar be notified at	District of Columbia	or Location Washington		10d. Inside City Limits 1 ☑ Yes 2 ☐ No					
ath with the Meryle 23s or 28s-f should the notified at	10e. Street and Number	10f. Zip Code	10g. Citizen of V						
	400 Aspen St., N.W. 11. Maritel Status 12. Wes Decedent Ever in U.S. Armed Forces?	20012 13. Wes Decedent of Hispanic Origin? (S If Yes, specify Cuben, Mexican, Puer		ed States e-American Indien, ck, White, etc.					
urs o	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Detes:	1 ☐ Yes 2 ☒ No Specify:		· Black					
n 72	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+)	Decedent's Usual Occupetion (Give kind of work done during most of world life. DO NOT use retired)	16b. Kind of Bu	usiness/Industry					
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12 should be filed who hend Mentel Hygien I is marked other the traumetic event, to To Re Co.	Henry Williamson		lah Massey						
ith end ith end its readment		Meiling Address (Street end Number or Re 1954 Rosemary Hills							
permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumetic once.	20e. Method of Disposition 20b. Placa of	Disposition (Neme of y, cremetory or other place)	Date 20c. Location -	City or Town, Stete					
Department Department Important: I any injury o		22 Name and Address of Facility		and, MD					
Depa Impo any is	Steered TIT	4001 Benning Rd.,	tewart Funeral						
	23a. Perf) Enter the disease, or complications that caused the death. Do n shock or heert failure. List only one cause on each line.			Approximate Intervel Between Onset end Death					
Physician /Medical Examiner	Immediate Cause (Final disease or condition e. Cardiac Arre	st							
THE REAL PROPERTY.	Due to (or es e c	consequence of):							
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cete be execut physician end the buriel-tran	Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events Due to (or es e control or est or injury) Due to (or es e control or est								
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the etten the etten thed for u	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Pert I.	23b. Did tobacco uss co	ntributs to the cause of death					
that the de ned by the deteched	Hypertension, Diabetis		1 Yss 2 No	3 Probably 4 Unknow					
The law requires that the deeth certific sete has been signed by the ettending page 2 should be deteched for use es.	Congestive heart failure		24e. Wes en eutopsy performed?	24b. Were autopsy findings eveileble prior to completion of cause of deeth?					
ysician: The law is certificate has director, page 2			1 ☐ Yes 2 No	1 Yes 2 No					
Physician: this certific ral director, To Be	25. Wes case referred to medical exeminer? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Out	Other	eth (Check only one) fome 5 ☐ Residence 6 ☐ Oth	nar (Snacihi)					
After th funeral	27. Magner of Deeth 1 Auturel 5 Pending (Month, Dey Year) 2 Accident investigation		28d. Describe how injury occur	red					
To the Hospital or Attending P. within 24 hours effer death. To the Funeral Director: Affer the completely filled in by the funeral Medical Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fer building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, Stete)							
n 24 hours n 24 hours ne Funeral pletely filled	29e. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)	deeth occurred et the time, dete end plect for Investigetion, in my opinion, deeth occurred	t, end due to the cause(s) end mo irred et the time, date end place,	enner es stated. and due to the ceuse(s)					
To the i	29b. Signature end title of cartifier 29c. License number 29d. Date signed (M								
m	Beight Schoollman M. D	24175 Z	2/24/9	79					
	30. Name and address of person who completed cause of death (Item 230) (Be Rait Schoell mann Hairs Permy	meste 10 x10 Cm	nectical and	· Hersinet					
State	31. Dete filed (Month, Day, Year) 32. Registrer's Signature		- Land	1. Y					



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First Middle Last) 2. Dete of Death 3. Time of Death **Physician** GIO PM FEBRUARY 27 /Medical (If not institution, giva street and number) 4b. City, Town, or Location of Daeth Ayatts will MP 30783 **Examiner** Hours Min Ct 10 16 1 5 Social Security Number If Undar 1 Yaar 6. Sax 9. Birthplece (State or Foreign Country) ga (In yrs. lest birthdey) **Funeral** 1□ M 200E Deys 408-03 Yrs Director Usuei Residence of Decedent Hyattrille 10e. Stete 10b. County 10c. City, Town or Location 28a-f show 10d. inside City Limits "natural", or items 23a or 28a-f show Director 1 XYes 2 □ No 10e. Straet and Number 10f. Zip Code 10g. Citizen of Whet Country? 8 20 Funeral death Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - Amarican Indien, Bleck, White, etc. filed within 72 hours after 1 □ Navar Married 2 □ Married 1 ☐ Yes 2√7 No If Yes, Give Yaar or Dates: Baltimore, Maryland 21215-0020 1□ Yas 2□No Specify: White Completed by 3 Widowed 4 Divorced Peges 1 and 2 should be filed within 72 hound of Health and Mantal Hygiena.
Int: If Itam 27 is marked other than "natur 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retirad) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Unknown
18. Mother's Name (First, Middle, Maiden Sumeme) Unknown 17. Fether's Neme (First, Middle, Last) Be Unknown Unknown 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) Rosemary Mason/Guardian 5012 Rhode Island Ave. Hyattsville MD 20781 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Dete 1 Buriel 2 Gremetion 3 Ramovel from State 4 Donetion 5 Other (Specify) permit. Pege Depertment of Important: If any Injury or Metropolitan Crematory3/6/99Alexandria, VA
22. Name end Address of Facility Takoma Funeral Home 21. Signature of Funday 254 Carroll Street Washington, DC 20012 234. Part1. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hand t failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical immediate Causa (Finel diseasa or condition resulting in deeth) Tenoscherote Cardisvasco las Disease Examiner Due to (or as a consequenca of) The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): P.O. Box 68760, Physician/Medicai the Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Dld tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, þ page 2 should be Completed 24b. Were eutopsy findings evellebie prior to completion of cause of deeth? 24a. Was an autopsy IV dead tus cillin Resistant Haph auxeus feps is certificate 1 ☐ Yes 2 TANO 1 ☐ Yes 2 ☐ No Division of Vital septal or Attending Physician: The hours after death.

neral Director: After this certificate y filled in by the funeral director, pa 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Rasidence 8 Other (Specify) 1 Yes 2 No Medical Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending 1 Neturei 1 ☐ Yes 2 ☐ No investigetion 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Piece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, dete end plece, end dua to the ceuse(s) end menner es steted.
2 Medicat Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) and menner stated. 29b. Signeture and title of certifier 29d. Date signed (Month, Dey, Year) led cause of deeth (item 23e) (Type, Print) seensbury Rd Hyattsville MD 20781 31. Dete filed (Month, Dey, Yeer) 32. Registrer's Signeture State MAR 0 2 1999 Registrar

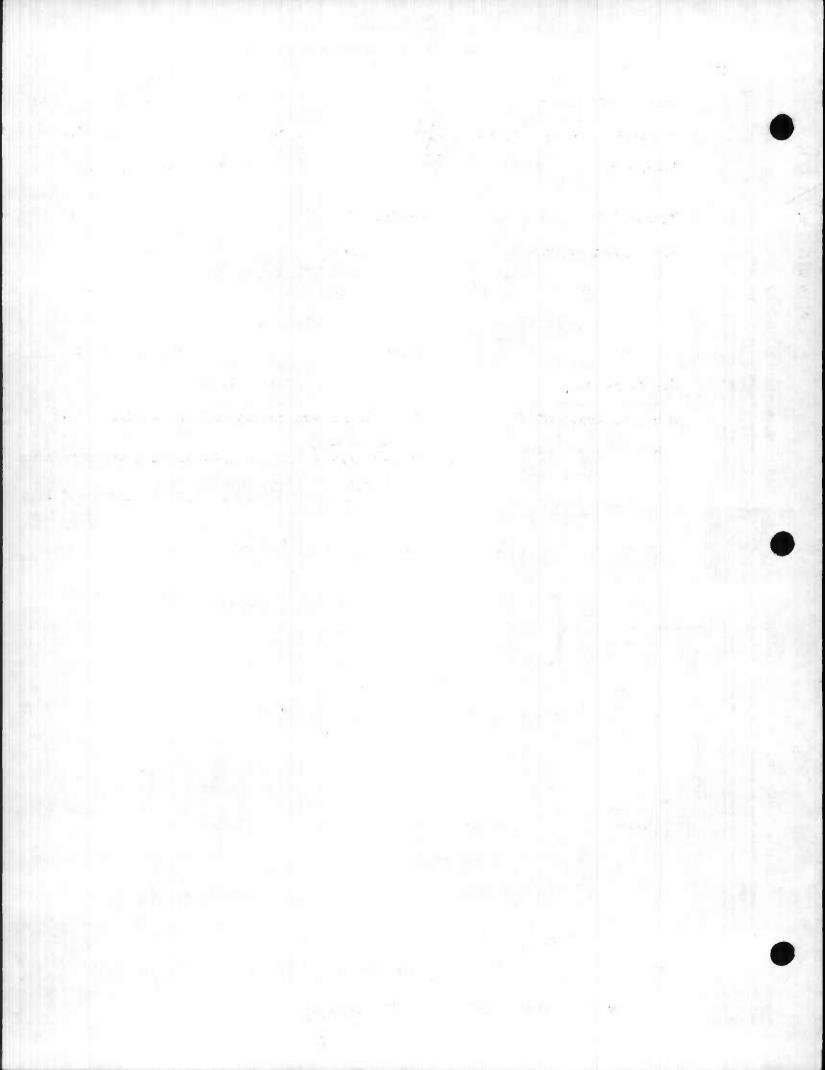


Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legit	ole.			
State of Maryland / Department of Health and Mental Hygiene	0.0	0	\cap	1

ITEM:	#20B PER F.G. G769 3-2	4-99 WR.	C	ertificate d	of Death		Reg. No.	UO	701			
	1. Decedent's Name (First, Middle, Li				2. Dete of Deeth		3. Time of Deeth					
Physician /Medical	Owen Leroy Widdo	WS			March	41 19	199	1:00pm				
Examiner	4a Fecility Name (If not institution, gi Washington County				Hagers		Washington Cou		County			
Funeral Director		Sex 7. Age (In yrs	s. last birthda 87 Yrs.	y) If Under 1 Ye Months Da		in. 8. Date of Bir	1911	Count	ece (Stete or Foreign try) land			
pu *	Usuel Residence of Decedent 10e. Stete 10b. County	10c. C	City, Town or	Location				10	Od. Inside City Limite			
the Maryland 28a-f show notified at	Maryland Washington Co. Hagerstown											
with the Maryls or 28a-f sho Los notfiled at	10e. Street and Number	10g. Citizen of	Citizen of Whet Country?									
	219 Calvert Terra	ace		217	42	153	USA					
or Items	11. Maritel Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorcad	Armed Forces? 1 ☐ Yes 2 ☑ Married If Yes Give			of Hispanic Origin? Cuben, Mexicen, Pu No Specify:	(Specify Yes or No erto Rican, etc.)						
	15. Decedent's E	ducation	16e. Dec	cadent's Usual Oc	cupetion		16b. Kind of Business/Industry					
ed within 72 ho ygiene. Nor than "naturi it, me Mexical Completed	(Specify only highest gr Elementery/Secondary (0-12)	College (1-4or 5+)	life	DO NOT use re	one during most of w tired)	vorking	19					
filed within Hygiene. ther then ent, treather	9	Fore	eman	10 Matheda h	lama /Finst Middle	Cement Company						
Aental H rked out tic ever To Be	17. Fether's Name (First, Middle, Las Roy F. Widdows	ly		18. Mother's Name (First, Middle, Meiden Sumeme) Katie Ridenour								
and 2 should selth end Men n 27 is marken or traumatic	19e. Informent's Name/Reletionship Mabel W. Widdows					Route Number, City or Town, State, Zip Code) erstown, Maryland 21742						
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 its marked other than eny Injury or other traumatic event, the Item one. To Be Compl	20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special Control of Control o	Dete Mar.08	20c. Location Hagerst		wn, Stete Maryland							
permit. Departr Imports eny Inju	21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Ma											
	23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximate Interval Between Onset and Deeth Immediate Cause (Finel disease or condition Approximate Interval Between Onset and Deeth Deeth Approximate Interval Between Onset and Deeth Death											
Physician												
/Medical Examiner												
_	resulting in death)	Due to	(or es e cons	sequence of):		V			l			
executed in and iet-transit	Sequentially list conditions, Due to (or es e consequence of):											
	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or as a consequence of):											
N so		d										
the att	Pert II. Other significent conditione	tobacco use co	e contribute to the cause of death?									
ned by e detect	Jensof Ch.	vorme 0/83	fmln	e Kwu	me Doc	20P 15	Yes 2 No	3 Probably 4 Unknown				
The law requires that the death ce rate has been signed by the attendings 2 should be deteched for use Completed by Physician/	24e. Wes en eutopsy performed? 24b. W								ere eutopsy findings allable prior to mpletion of cause deeth?			
The law ate hes page 2	1 Yes 2 46								Yes 2□ No			
ysiclen: The scerificate director, pag	25. Was case referred to medical examiner?				26. Plece of [Deeth (Check only	one)					
Physician: rthis certific and director, TO Be	1□ Yes 2□ No	I	-	tient 3 DOA		g Home 5□ Res			v)			
Ing P. After t	27. Manner of Death 1 Neturel 5 Pending	28e. Dete of Injury (Month, Day Year)	28b. Time Injur		Injury et Work?	28d. Describe	how Injury occu	rred				
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di Medical Certification: To	2 Accident Investigation 3 Suicide 6 Could not lead to determine determined	De Diago of Injury At	home, farm,		1 Yes 2 No		(Street end Num own, Stete)	ber or Rure	I Route Number,			
	29a. Certifier (Check only one) 29a. Medical Examiner: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. (Check only one) 29a. Certifier (Check only one)											
	29b. Signeture and title of cedifier 29c. License number 29d. Date signed (Month, Day, Year) 3 4 95											
	30. Name and address of person who	sompleted cause of death (It	em 23a) (Typ	pe, Print) a l	c hill	ave,	Hage	3500	21747			
State Registrar	31. Dete filed (Month, Day, Year) MAR 0 8 1	999 32. Registrer's Sign	neture	4. Spo	rely		/		- , - , -			

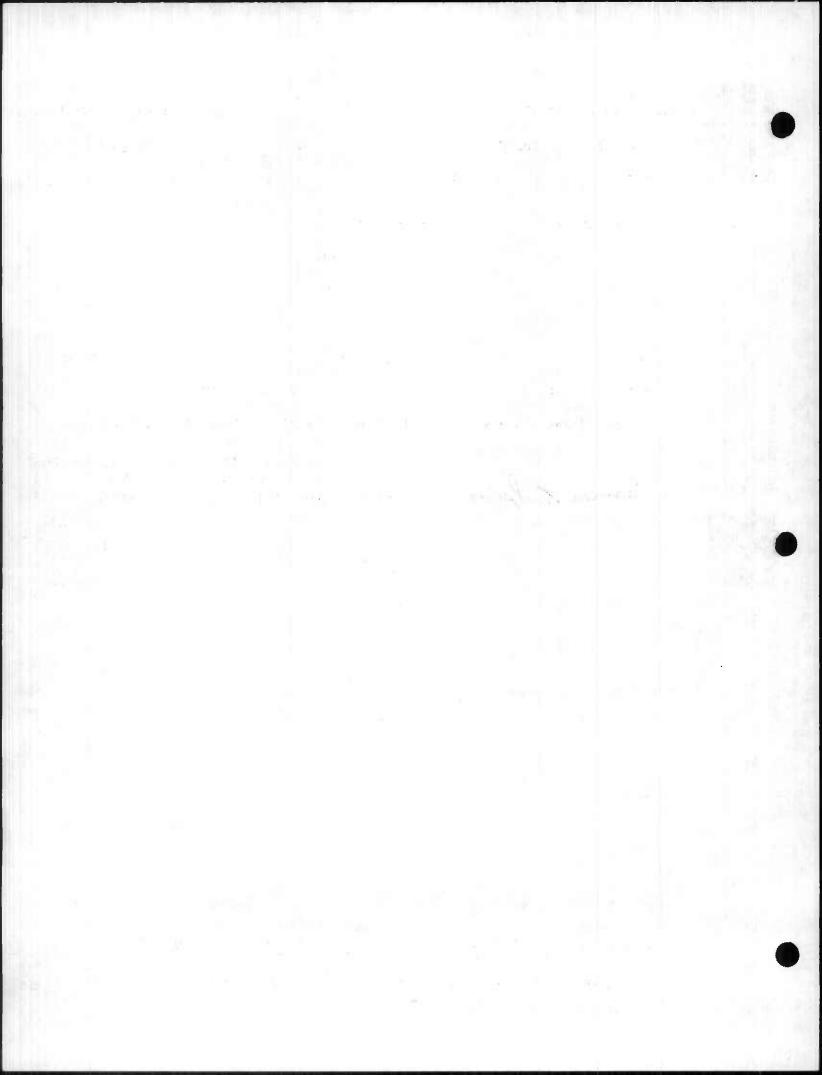


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Daath 3. Time of Death **Physician** WELTIE WESLEY WILES 1999 March 8 12:45 a.m. /Medical 4a. Facility Name (If not institution, giva straet end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Colton Villa Nursing Center Washington Hagerstown If Undar 1 Yaar If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** Birthplace (State or Foreign Country) Days 1X) M 2□ F Yrs Director 214-16-0199 April 2 1915 Maryland Usuai Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits item 27 is marked other than "naturel", or itema 23a or 28a-f show other traumatic event, the Mapical Examiner must be notified at 1 Yes 2 □ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? death with 224 Summit Avenue U.S.A. 21740 Funerai Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mantal Hygiena. Important: If item 27 is merked other than "naturel", or item will july or other traumate. Black, Whita, atc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☑ Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Coilege (1-4or 5+) 0 . 6 Laborer City Government 17. Father's Nama (First, Middle, Lest) 18. Mother's Name (First, Middla, Malden Sumema) Be Raymond W. Wiles 2 Rosa E. Michael 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Jennie Mae Kyler - Sister 9512 Downsville Pike Williamsport, Md. 21795 20a. Method of Disposition 20b. Piace of Disposition (Nama of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Paul's Lutheran Cem. 3/10/99 Myersville, Maryland 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funarai Service Licensae 415 E. Wilson Blvd. Hagerstown, Maryland 21740 Part1. Entar the disease, or complications that ceusad tha daath. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on aach line. **Physician** /Medical Immediate Cause (Final disease or condition rasulting in death) HTHEROSCIEROTIC CARDIO VASCULAN DISEASE MINS Examiner Due to (or as a consequence of): Examiner ANGENTIA 24 hours physician and the burial-transit Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): 7 AILURE RENAL Box 68760. 2 years Physician/Medical attanding p CEREBNOVASCULAR Lyear P.O. Part Ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, þ Completed 24a. Was an autopsy 24b. Were autopsy findings peeu available prior to completion of cause of death? 2 1 No 1 ☐ Yes 2 No 1 🗆 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this carlification plately filled in by the funeral director, Be 25. Was case referred to medicei examiner? 26. Piaca of Death (Check only one) Hospitai: Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 Yas 2 TNo Certification: To 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Daath 28c. injury at Work? 28a. Date of injury (Month, Dey Year) 28d. Describe how injury occurred 5 Panding investigation 1 Naturai 1 Tas 2 No 2 Accident 6 Could not be datamined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Phyalcian: To tha best of my knowledga, daath occurred at the tima, data and piace, and due to tha cause(s) and mannar as statad. Medical 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signature and fitla of certifian 29c. License number 29d. Data signed (Month, Dey, Year) D28365 30. Name and address of person who completed ceuse of death (Itam 23a) (Type, Print) MILL STREIST HAGERSTOWN 368 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State MAR 0 9

Registrar



State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** NELLIE **AGNES** YOUNG Febuary 1999 26 9:30pm /Medical 4a. Fecility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner CIVISTA MEDICAL CENTER LA PLATA CHARLES 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1□M 2⊠F Yrs. 579-32-3503 Director 79 1919 MARYLAND Usual Residence of Decedent the Marylend 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be nutried as 1X Yes 2F No Director CHARLES WALDORF MARYT AND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12141 ELL LANE APT. #18 20601 UNITED STATES death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: λq Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 15. Decedent's Education 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grede completed) should be filed within 7 and Mentel Hygiene. FOOD SERVICE Elementary/Secondary (0-12) 7th College (1-4or 5+) RETIRED CAFETERIA WORKER CHARLES CO. BOARD OF ED 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Pages 1 end 2 should be lent of Health end Mentel int: if item 27 is marked or JOHN ANDREW YOUNG ELIZABETH CORINE LYLES YOUNG 2 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) REGINALD L. YOUNG SR. / SON 15060 REGINA AVE. BRANDYWINE, MARYLAND 20613 20a. Method of Disposition 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20c. Location - City or Town, State 1 ☑ Burlei 2 ☐ Cremetion 3 ☐ Removal from State permit. Page Department o important: if any injury or 3/2/99 ZION CHURCH CEMETERY WALDORF, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signifiure of Fundral Service Lipenson

NOTA C. THORNTON JOHNSON 22. Name end Address of Facility THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTION ROAD INDIAN HEAD, MD 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate intervei Between Onset and Death **Physician** /Medical BACTERIAL immediate Cause (Final TNEUMONIA disease or condition resulting in deeth) Examiner Examiner QUAMMONS CELL CARCINOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? by the CHRONIC DBSTRUCTIVE DISEASE LUNG 1 ☐ Yss 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Ugnes þ 8 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes an eutopsy performed? peed HYPOXEMIA page 2 2 No certificate 1 Yes 1 ☐ Yes 2 No director. Be 25. Was case referred to medical 26. Plece of Death (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ≥ No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of Medical Certification: 28e. Date of Injury (Month, Dev Yeer) 28c. Injury et Work? 28d. Describe how injury occurred After 1 Neturel 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 2 4 Homicide To the Hospital within 24 hours e Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end pleca, and due to the ceuse(s) end manner stated. 29a. Certifier 99b. Signature 29c. License number naftitie of certifier 29d. Date signed (Month, Dey, Year) Ramanan 27 D - 0553886 99 30. Name end eddress of person who completed cause of death (item 23a) (Type, Print) Venkat Ramanan, MD 7501 Surratts Road, Suite 307, Clinton, Maryland, 20735

DHMH 16 Rev 6/95

State Registrar

31. Date file MAR Day Yes 1999

37. Registrer's Signeture

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AND THE PARTY

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 3 Time of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 99 03 -AM KOGERSTINE ADDISON /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner GRANTLEY BALTIMORE NIA STREET If Under 1 Year | If Under 24 Hrs. Birthplece (Steta or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) 12 M 20 F 249.66-1438 Yrs 02-10-36 Usuet Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 Yas 2 No Director NIA 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code STREET 21229 GRANTLEY USA Funeral 13. Was Decedant of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedant Ever in U,S. Armed Forces? 14. Race -Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give 1□ Yas 2⊡No Specify: Specify: BLACK 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. QO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LEANER JANITORIAL 10 TH GRADE NA 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Name (First, Middle, Last) Be SAUL ELDISE ADDISON DAVIS 2 19a. Informant's Name/Relationship (Type, Print) 19b. Malting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SISTER 882 ST. STEPHEN P.O. BOX VIRGINIA ADDISON 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3.20.99 4 ☐ Donation 5 ☐ Other (Specify) ING ARK 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BAUTO. NATL' PIKE, BAUTO, MD 10 23a. Part1. Enter the diseas shock, or heart failure Approximate tntervat Batween Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory List only one cause on each line. Immediate Cause (Finat disease or condition resulting to death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or thjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? 1 Nos 2 No 3 Probably 4 Unknown 1502 à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 TYes 1 □ Yes 2 □ No 2000 Be 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Yeer) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how tnjury occurred 1 @Natural 5 Pending Investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be datermined 3 Suicida 281. Location (Street end Number or Rural Routa Number, City or Town, Stete)

Division of Vital Records, P.O. Box 68760. certificate be I or Attending Physician: effer death. Director: After this certific To the Hospital c within 24 hours of To the Funeral Di

Funeral

Director

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7 is marked other than "natural", or itams 23s or 28s-f show traumatic evant, an Modical Experience must be notified at

permit. Pages 1 and 2 should be filled within 7 Department of Heelth and Mentel Hygiene. Important: If Item 27 Is marked other than "ready lighty or other traumatic event," restronting.

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Baltimore, Maryland 21215-0020

State Registrar

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29b. Signature and fitte of certifier

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(Check only one)

29a. Certifier

WATERFIELD MI)

9'00 32. Registrar's Signeture

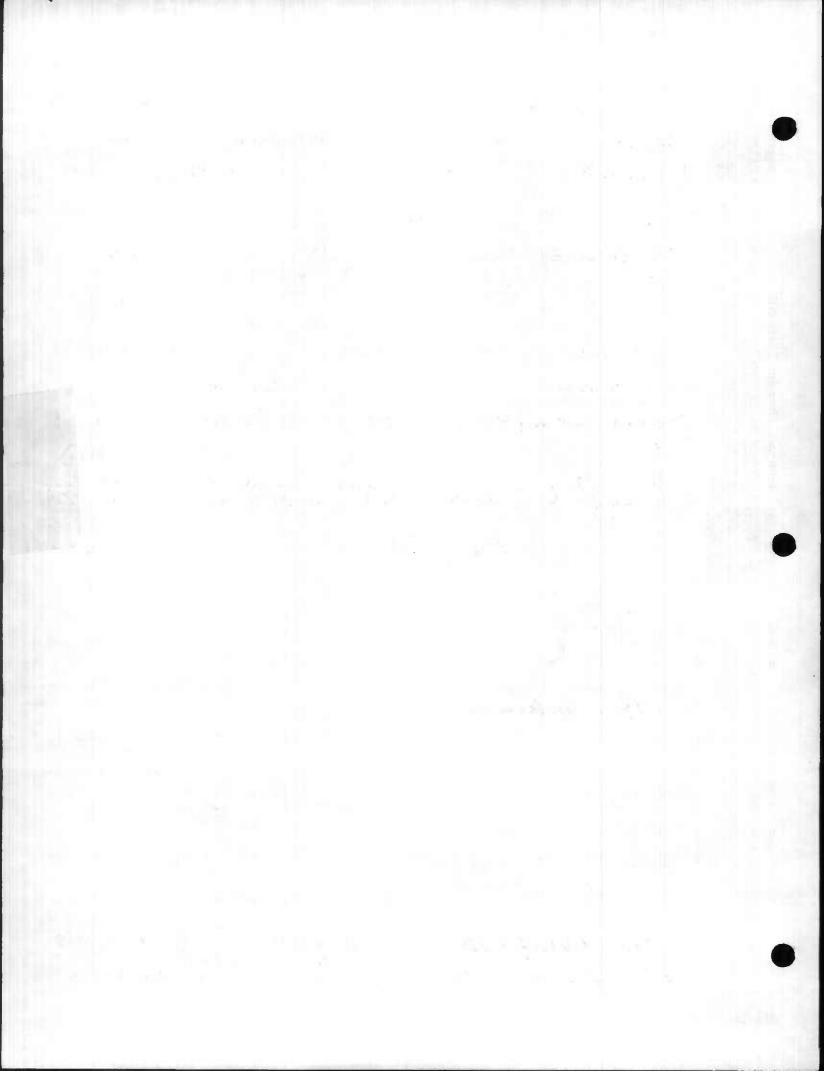
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physicfan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

> 29c. License number 024356

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St Agnes Concer Center Win C WATEREID MID 900 At Ace Balt W/2122



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month **Physician** march 1999 1:30 am Adams Huzel /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Silver Spring Montgomer /
Birthplace (Stetl or Foreign Country) Bedford Court Itea Ith Care Center

5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Unx 8. Date o Birth (Month, Dey, If Under 1 Year 1910 Wash DC 1□M 2√F Months Hours Deys 88 579 10 0223 Yrs. Oct. 14 **Director** Usuel Residence of Decedent the Maryland 10d. inside City Limits 10b. County 10c. City, Town or Location 10e. Stete 28a-f show 7 is marked other than "natural", or items 23s or 28s-f shor traumstic event, tra Medical Examinar must be notified at Yes 2 No Washington DC Director 10e. Street and Number 10g. Citizen of Whet Country? Street, N.V.

12. Wes Decedent Ever in U,S.
Armed Forces?

1 Ves 270 No
If Yes, Give
Year or Detes: 454 4904 - 9th N.W. 20011 Funerai 2 should be filled within 72 hours after death vent Mental Hygiena.
Is marked other than "natural", or frems 23. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1□ Yes 2 No altimore, Maryland 21215-0020 Specify: Black. Specify: þ 3 Widowed 4 ☐ Divorced Completed 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Treasurer Dept. Audit Examiner 1244. 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) margaret Hawkins Ananias Brooks 19b. Mailing Address (Street end Number of Aural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) permit. Pages 1 and 2 sh Department of Health end Important: If Item 27 is m eny injury or other traum page. 9609 Stoney Brook Dr. Keningston md 20895 lean M. Veazey 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State Buriel 2 Cremation 3 Removel from State 3-22-99 Laurel, Md. Donetion 5 Other (Specify) Maryland Nat. T. Rhines Co. 22. Name and Address of Fecility 21. Signeture of Funerel Service Licensee 724 3030 - 12th. St disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, ailure. List only one cause on each line. 2Va 3030 - 12th. St. NE. Wash DC 20017 23a. Pert1. Enter shock, or he Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Final diseese or condition resulting in deeth) /Medicai . Artheroscleratio Years Examiner Examiner attending physician end for use es the burial-transit requires that the deeth certificete be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or es e consequence of): Box 68760, Physician/Medical that initieted events resulting in deeth) Lest Due to (or es e consequence of): P.O. ed by the a Pert II. Other significant conditions contributing to death but not resulting In the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed The law certificate hes 1 Yes 2 No 1 Yes 2 No Attending Physician: 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 After this c 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Yeer) 28b. Time of Certification: 1 Natural 5 Pending investigation To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Af completaly filled in by the fu 1 Yes 2 No death. 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end manner es stated. cai 29a. Certifier 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 33357

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State Registrar 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Than

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31. Date filed (Month, Day, Year)

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32. Registrer's Signeture

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Anna Barbour expired March 16,1999 e 11:45Am

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:45 AM Anna Dorothy Barbour March 16,1999 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Gilchrest Hospice of Baltimore Towson Baltimore Co. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) August 3,1928 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 214-24-6052 1 □ M 2X3 F 70 Maryland Yrs Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23s or 25s-4 show traumatic event, the Medical Examinar must be notified at Maryland Anne Arundel Pasadena 1 Yes 2 No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 101 Wileys Lane 21122 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, spacify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: specify: White p 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health and Mentel Hygien. Important: If item 27 is marked other that any injury or other traumetic event. Barmaid Lou's Bar 12 N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert F. Myrick Anna Craig 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs Janet L. Gallo Daughter 101 Wileys Lane Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 DeBurial 2 Cremation 3 Removal from State Oak Lawn Cemetery March 18,1999 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Furieral Service Cens 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Fart1. Enter the dis shock, or heart hill 21122 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) deno core noma 3 months **Examiner** Due to (or as a consequence of) Physician/Medical Examiner that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Due to (or as a consequence of) 98 23b. Did tobacco use contribute to the cause of death? Part II. Other stanfficant conditions contributing to death but not resulting in the underlying cause given In Pert I. the 1 Yes 2 40 3 Probably 4 Unknown signed by Division of Vital Records, 2 24b. Were autopsy findings available prior to 24a. Was en autopsy Completed peen s completion of cause of deeth? has 1 ☐ Yes 2 No certificate Physician: 25. Was case referred to medical examiner? Be 26. Piace of Death (Check only one) Gilchrest Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Lo 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: After t or Attanding 5 Pending Investigation 1 Natural s efter deeth.

I Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide in by 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours of Tertifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner es steted.

2 Madical Examinar: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner steted. edical 29a. Certifie (Check only one) To the 29b. Signature and ille of pertifier 29d. Date signed (Month, Day, Year) 29c. License number

N. Charles St.

March 16, 1999

Balto. md

State Registrar 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

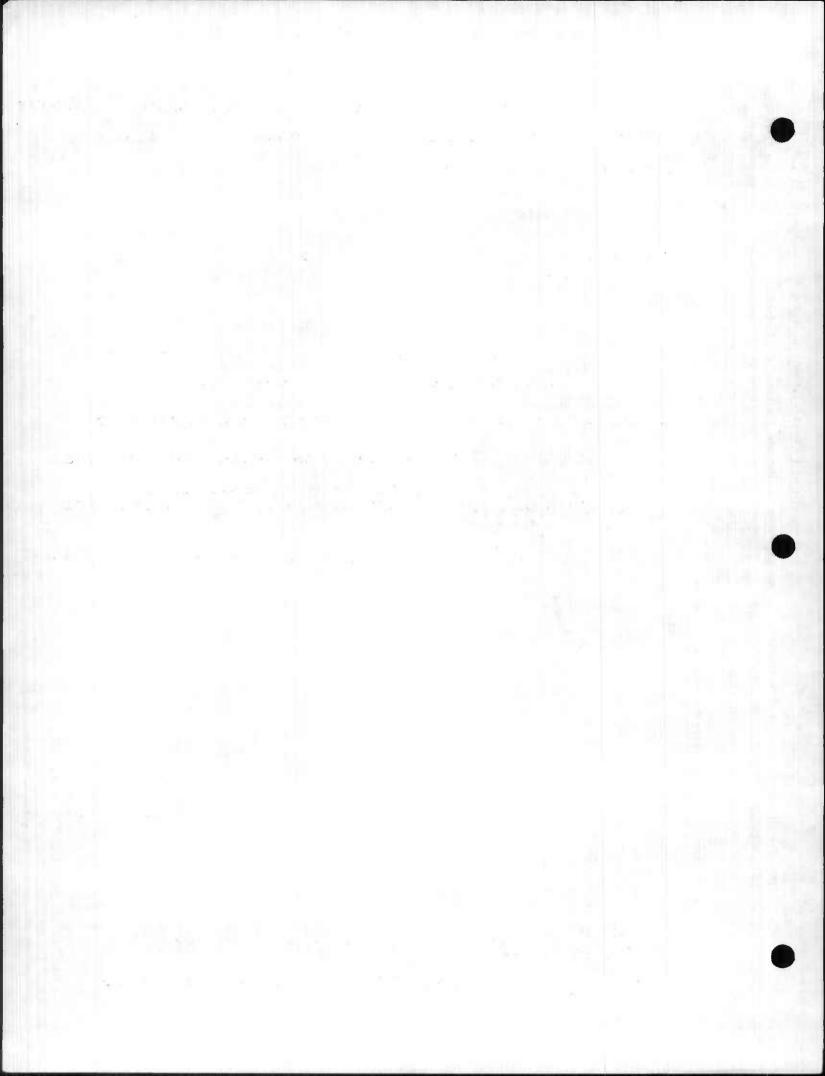
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nc (670)
32, Registrar's Signature

Riley

MAR 1 9 1999

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth ^{Dey} 1999 **Physician** MARCH 16 1:35 AM CATHERINE A. BIDDINGER /Medical 4e. Feclity Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore 1808 S. Charles Street If Under 1 If Under 24 Hrs. Birthpiece (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dev. Yeer) **Funeral** 1 M 2 XF 71 Vrs Director 212-22-1545 Feb. 09 1928 Maryland Usual Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Macical Examinar must be not fled all n/a Baltimore Md. Director Yos 2□No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21230 USA 1808 S. Charles Street Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American indien, Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 2 should be filed within 72 hours after n end Mantal Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 white by 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) Domestic Housewife Home Owner 9 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Iola Hornsberger Harry Stein, Sr. 19e. Intorment's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2 Department of Health e Important: If Itam 27 is any injury or other trau 3816 8th Baltimore, Md. 21225 Roland L. Biddinger, Jr. (Son) 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 3/18/99 Brooklyn, Park, Md. Cedar Hill Cemetery 21. Signeture of Funeral Servica Licenses 22. Name end Address of Fecility McCully-Polyniak Funeral Home P.A. 23a. Per 1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, App. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediete Cause (Final VARIAN CARCINOMA mos disease or condition resulting in deeth) Examiner Examiner tren Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest and Due to (or es e consequence ot) physician the burial Box 68760 Physician/Medical Due to (or es e consequence ot) esn 0 P.O. Part Ii. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en autopsy performed? Completed 2. No Division of Vital Hospital or Attanding Physician: 24 hours after death.
 Funeral Director: After this certifical letaly filled in by the funeral director, 25. Wes case reterred to medical Be 26. Plece of Deeth (Check only one) 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end pieca, end due to the ceuse(s) end menner es stated. Medical (Check only one) 2 Madical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated.

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State Registrar 29b, Signature and title of certifie

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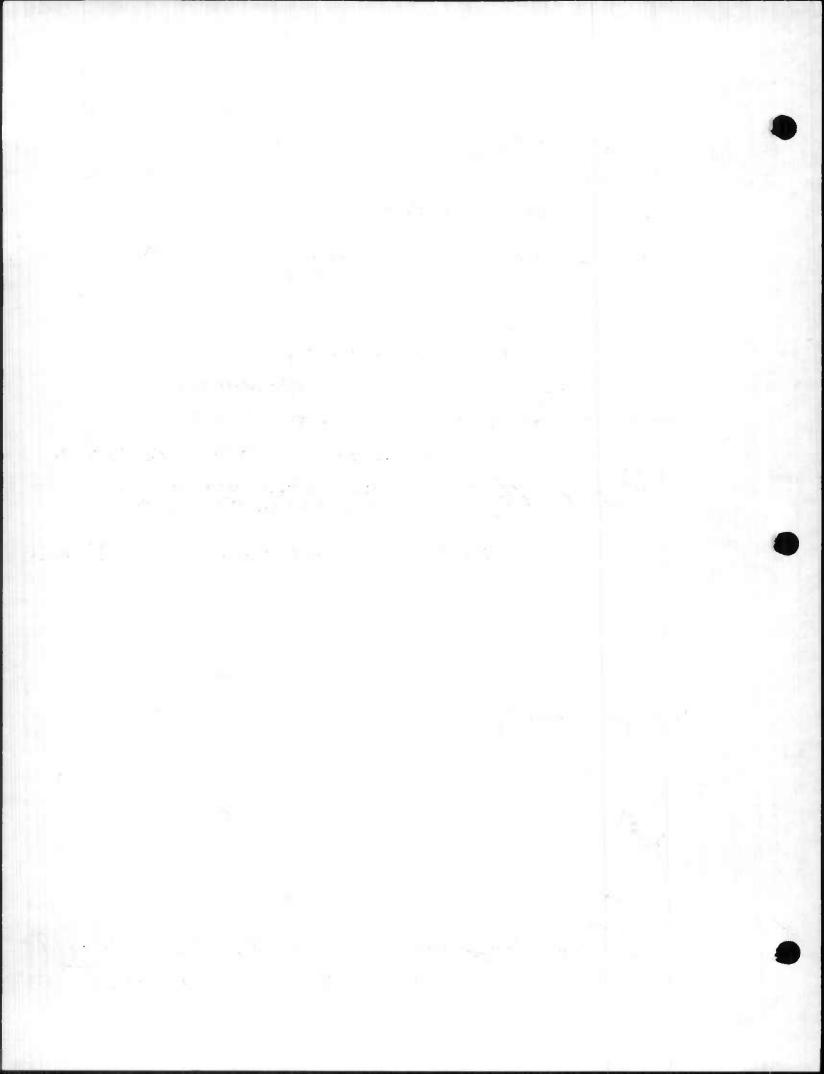
30 Name and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

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Registrar's Signeture

S. Hanover

within 2 To the Complet



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Yee **Physician** Sheila Ann Bevel 16, 99 15:00pm Mar. /Medical 4b. City. Town, or Location of Death 4a Facility Nama (If not institution, give streat and number) 4c. County of Death Examiner Johns Hopkins Hospital Baltimore 7. Age (In yrs. lest birthday) If Under 1 Yaar | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1□ M 2 F 220-64-8979 MD Director 05-04-55 Usual Rasidence of Decedent with the Maryland 10c. City, Town or Location 10d. inside City Limits 10a. Stete 10b. County r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at Baltimore MD NA 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21229 4515 Cedar Garden Road daath v Funeral Was Decedeni of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, Whita, atc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Status parmit. Pagas 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or item eny injury or other traumatic event, the Medical Evantine Once. 1 ☐ Yas 2X No If Yes, Give 1 Nevar Marriad 2 Married 1 ☐ Yes 2 ☐ No Specify: by n Yes, Give Year or Daies: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elemantary/Secondery (0-12) College (1-4or 5+) High Sch. Grad NA Company Clerical 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Surnama) Richardson Eugenia 2 Bevel, Jr. Marco 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 9543 Painted Tree Drive Randstalltown, MD Winstead Rosalee 20b. Plece of Disposition (Neme of cematery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date Greenmount Cemetery 03-20-99 Baltimore, MD 1 Buriel 2 Cremation 3 Removal from Stete 4 Donation 5 Other (Specify) 22. Name and Addrass of Facility 21. Signature of Funeral Servica Licensae 22. Name and Address of Facility
WM.C.March FH 1101 E.North Avenue mond mous 23a. Pert1. Enter the diseasa, or complice shock, or heart feilure. List only Approximate Intarvai Between Onset and Death his that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Physician /Medical Immediata Cause (Final disease or condition rasulting in daath) Examiner Due to (or as a consequence of): Physician/Medical Examiner ewstr attending physician and for usa es the buriel-transit The law requires that the death certificeta be executed Sequentially list conditions, if any, leading to immediata cause. Entar Undarfying Causa (Disaesa or injury that initiated events resulting in deeth) Lest Due to (or as e consequance of): Division of Vital Records, P.O. Box 68760, Dua to (or as a consequence of): signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings availebla prior to completion of cause of death? been sig Completed 24e. Was an autopsy has ne 2 ils cartificate had 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) Hospital: 1□ Yes 2 No Othar: 4 Nursing Home 5 Rasidance 6 Other (Specify) 2 1 Inpatiant 2 ER/Outpatient 3 DOA Aftar this nin 24 hours after death.

the Funeral Director: After this
npletely filled in by the funeral of 28a. Data of Injury (Month, Dey Year) 27. Manner of Death 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? 5 Pending Investigation 1 Natural 1 TYes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, sireet, fectory, offica building, atc. (Specify) 4 ☐ HomicIda Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and menner as stated. 29a. Certifier edical (Check only within 2. To the F 29b. Signature and little (29c Licansa number 29d. Date signed (Month, Day, Year) 3/19/99 30. Nama and address of person who compiated causa of daath (Itam 23e) (Type, Print)

Dr. Joseph A. Soliman, MD 3421 Benson Ave Suite#350 Balto, MD. 21227

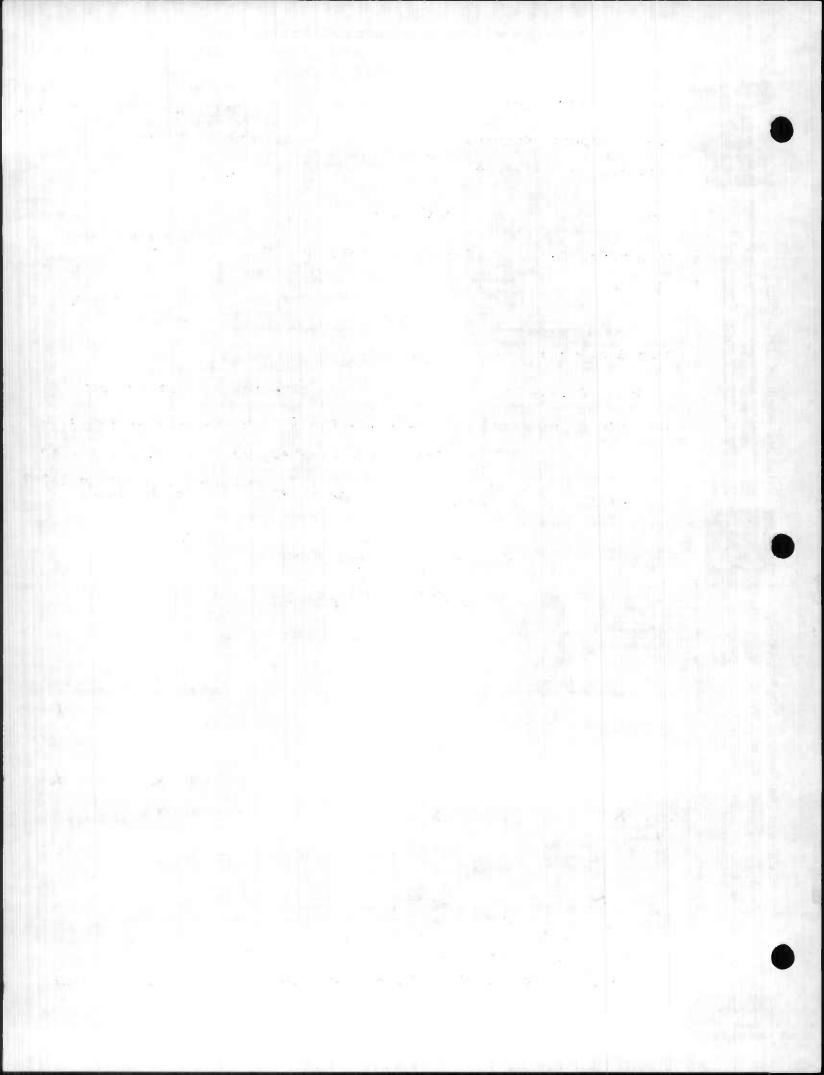
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State

31. Dete filed (Month, Day, Year)

MAR 1 9 1999

32. Registrar's Signature

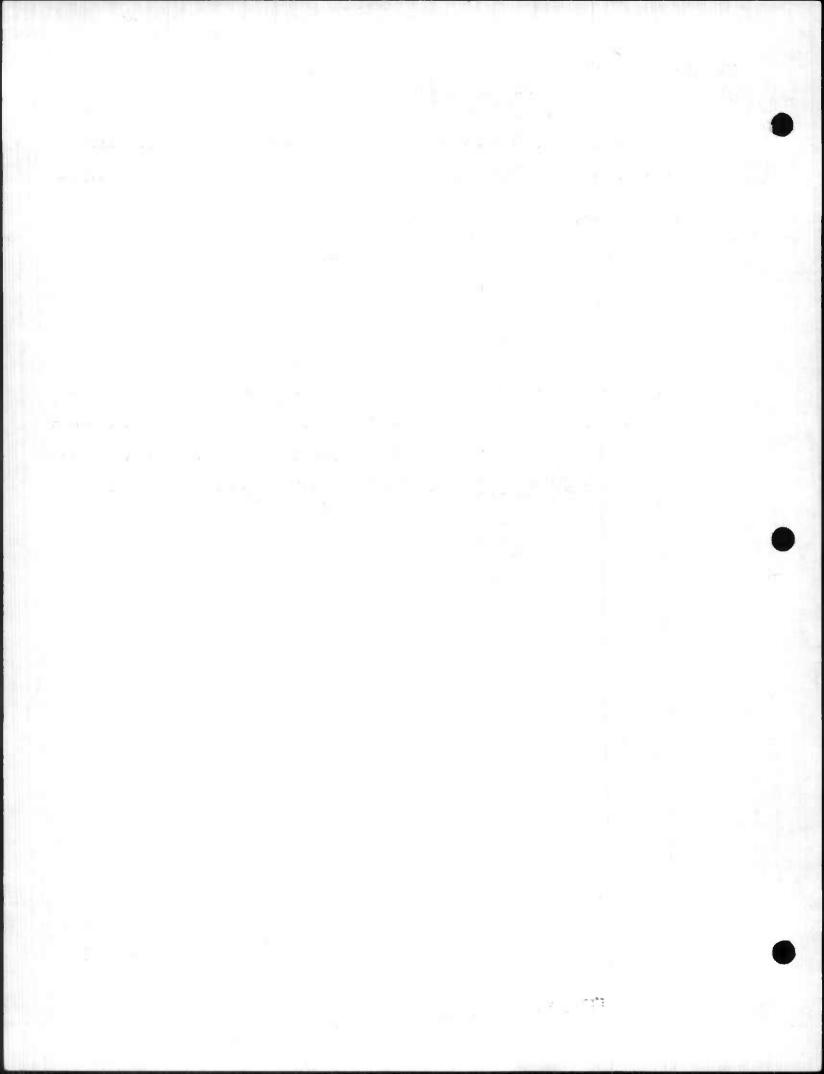


State of Maryland / Department of Health and Mental Hygiene

ITEM: #1 PER MD G769 3-19-99 WR. Certificate of Death 1. Decedant's Name (First, Middle, Last) BEATRICE RAFFERTY BEST 2 Date of Death 3. Time of Death Month **Physician** 150 BRa THICE 16 07 18 /Medical 4e. Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner ST. CATHERINES NURSING CENTER **EMMITSBURG** FREDERICK 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Dey, Year) 6 Sax Birthpleca (State or Foreign Country) **Funeral** Months 1□ M 2□N€ Deys Hours Min Yrs. Director 220-42-5422 PENNSYLVANIA Usuel Residence of Decedent the Meryland 10a Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "netural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 No Yes 2 No Director MARYLAND FREDERICK THURMONT 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 509 E. MAIN ST. 21788 USA deeth 11 Marital Status 12. Was Decedant Evar In U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14 Race - American Indian Bieck, Whita, atc. filed within 72 hours after 1 ☐ Yes 2 ☐ No It Yes, Give 1 Nevar Married 2 Merried 1 ☐ Yes 2 ☐ No 3altimore, Maryland 21215-0020 Specify à 3 X Widowed 4 ☐ Divorced WHITE Completed 18a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Heelih and Mental Hygiene. Important: If fem 27 is merked other than any Injury or other traumath. Elemantary/Secondary (0-12) College (1-4or 5+) 12 TEACHER PAROCHIAL SCHOOL 17. Father's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be JOHN Υ. RAFFERTY THERESA JANE McKEOWN 19e. Informent's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) KATHRYN B. CRAMER (DAUGHTER) 12 GALLORETTE CT., WALKERSVILLE, MD 21793-8134 20e. Mathod of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete MOUNT CARMEL CEMETERY 2/22/99 THURMONT, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Sarvice Licensell 22. Nama and Address of Fecility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 E. MAIN ST., THURMONT, MD 21788 23a. Part Ener the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiec or respiratory errest, or heart feilure. List only one cause on each line. Approximata Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner burial-transit Sequantielly list conditions, if any, laading to immedieta cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in deeth) Last pue physician s the burial-Records, P.O. Box 68760. Physician/Medical -51 Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Probably 4 Unknown signed by 1 Yes 2 No p 8 should t 24b. Were autopsy tindings aveilable prior to Completed 24e. Wes an autopsy complation of cause of death? 25. Was case ratarred to medical exeminer? certificate 1 Yes 1 ☐ Yas 2 ☐ No Division of Vital after deeth.

Director: After this certifice Be 26. Place of Deeth (Check only one) Othar: 1 ☐ Yes 2 No 2 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA funeral Menner of Daeth 28e. Deta of Injury (Month, Day Year) 28d. Dascribe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? Naturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 8 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, straat, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Dis completely filled in Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the ceuse(s) end menner es steted.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner steted. edicai 29e. Certifier (Check only one) 29b. Signature end title of certifian 29c. License number 29d. Dete signed (Month, Dey, Year) SETON who complated cause of death (Item 23a) (Type, Print) 310 RRUMPEL-EMMITSBURG. CUD 32. Registrum Signeture State 3 1999 Registrar

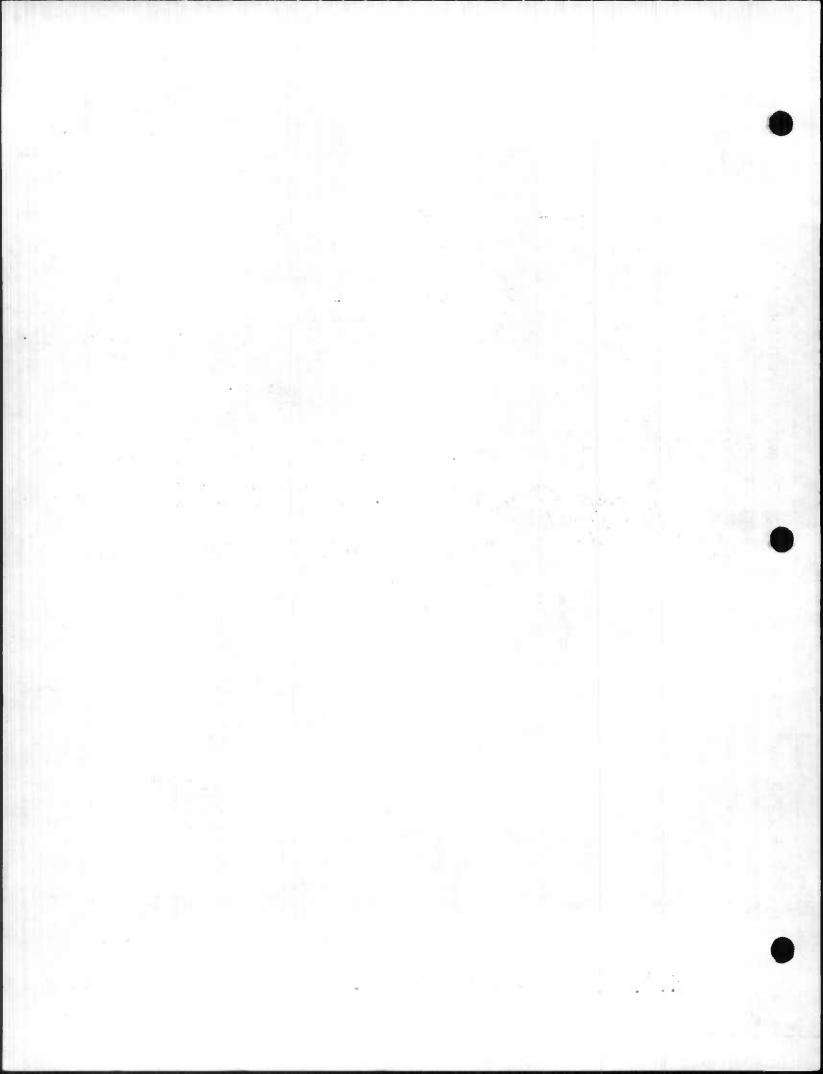


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Joseph D. Breslin 10 6:16 A.M. March /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Bowie 12411 Stafford Lane If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral Deys Months Hours 1₩ 2□ F 79 201 01 1882 Director March 22, 1919 Pennsylvania Usuel Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Yes 2□No Maryland Prince George's Bowie Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 20715 12411 Stafford Lane United States Nerna 23a Funeral 14. Race - American Indian, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? Yes 2 No If Yes, Give Yeer or Detes: 72 hours after 1 Navar Marriad Z Married Baltimore, Maryland 21215-0020 "natural", or 1□ Yes 2□ No Specify Specify: White WWII þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Department of 12 Grain Inspector Agriculture permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: if Item 27 is marked other
any injury or other traument. 17. Fether's Neme (First, Middla, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Teresa Shovlin Daniel Joseph Breslin 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Mary B. Breslin 12411 Stafford Lane Bowie Maryland 20715 20b. Place of Disposition (Name of cametery, cremetory or other place) March 15, Dete 20e. Method of Disposition 20c. Location - City or Town, Stete X⊠ Buriel 2 □ Crametion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Maryland Veterans Cemetety Cheltenham Maryland 22. Name and Address of Fecility Robert E. Evans Funeral Home, Inc. 21. Signature of Funerel Service Licensee 16000 Annapolis Rd. Bowie Maryland 20715 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or haart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Finel disease or condition resulting In deeth) /Medical lears Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician s the burial Box 68760, Physician/Medical Dua to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wera autopsy findings evaileble prior to completion of causa of death? Certification: To Be Completed 24a. Wes an autopsy performed? 1 Yes 2€No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4□ Nursing Home ¾ Pasidence 6□Other (Specify) 1 ☐ Yes AN No this funeral 27. Menner of Death 28b. Time of Injury 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? After **XXNatural** 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 24 hours after deat 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es steted.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. edical To the Hosp within 24 hox To the Fune completely fi (Check only one) 29b. Signature and title & 29c. License number 29d. Dete signed (Month, Day, Year) March 11, 1999 D 38031 pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who a perior Lane Dowie Mb 2014 M.D. 3231 Madalene 31. Deta filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 9 1999

DHMH 16 Rev 6/95

Registrar

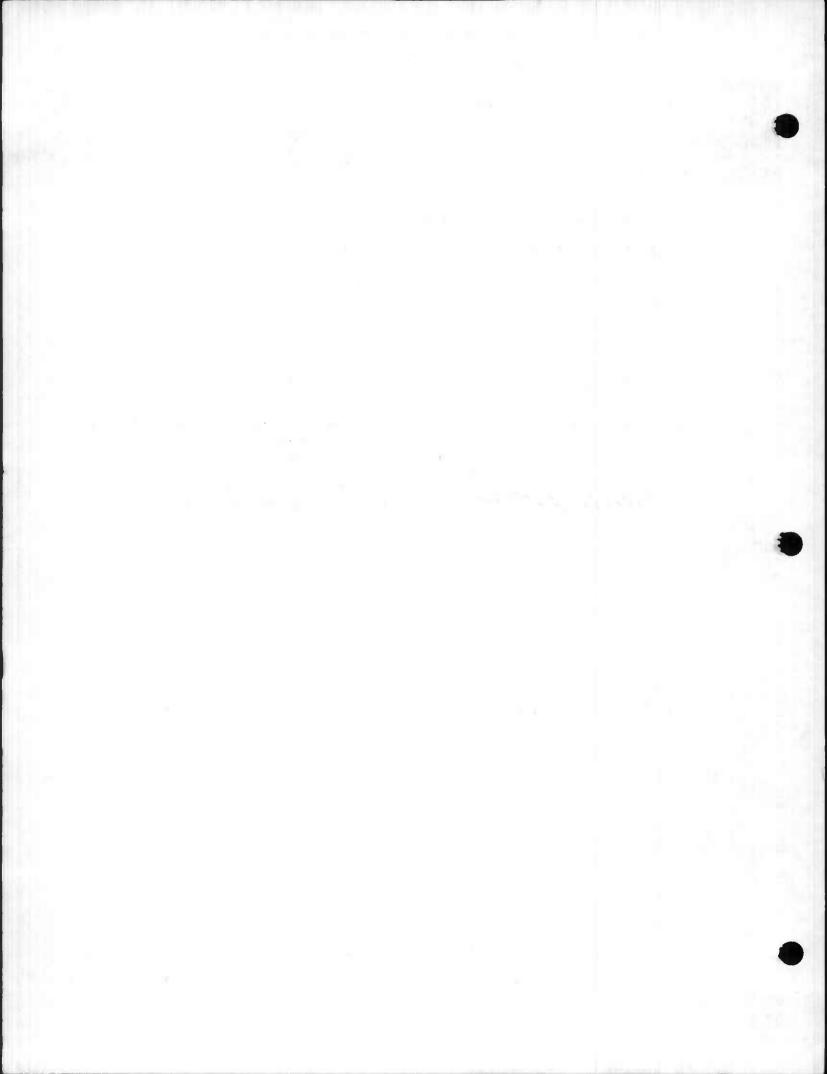


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 1

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** Month Bridgers 5.45 pm 1)0115 10 /Medical 4a. Facility Nama (If not institution, giva street and numbar). 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Home Ridge Nursina SYKESVILLE CARROLL 5. Social Sacurity Number 7. Aga (In vrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs. Birthplace (State or Foreign Country) 8. Data of Birth (Month, Day, Yaer) **Funeral** Days 217 44 7606 Months Hours 90 Director June 16 1908 Virginia Usual Rasidance of Dacedant with the Maryland 10b. County 10c. City, Town or Location items 23a or 28a-f show 10d. tnsida City Limits the Medical Examiner must be notified at Director 1√3 Yas 2 No Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 12908 Cherrywood Lane 20715 death v Funeral United States 12. Was Dacedant Evar In U,S. Armed Forces? 1 ☐ Yas 2 No If Yas, Giva 11 Marital Status Was Dacadant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian Black, Whita, atc. filed within 72 hours after 1 ☐ Nevar Marriad 2 ☐ Married Baltimore, Maryland 21215-0020 'natural', or 1 ☐ Yas Z No Specify: White PV Specify: 3 ☑ Widowed 4 □ Divorced Be Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona duning most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry al Hygiene. Elamantary/Secondary (0-12) Collaga (1-4or 5+) 0 Own Home Homemaker permit. Peges 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked othe any Injury or other traumatic event once. 17. Fether's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumema) Ola Phaup Marion Lee Newbill 2 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 8154 Quarterfield Farms Dr. Severn MD 21144 Robert L. Bridgers 20b. Place of Disposition (Nama of camatery, cramatory or other place) March 18, Date 999 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata Arlington Virginia Arlington National Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvica Licensaa 22. Nama and Addrass of Facility Robert E. Evans Funeral Home, Inc. ovon 16000 Annapolis Rd. Bowie Maryland 20715 23a. Fart1. Entar the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximata Intarval Batween Onsat and Daath Physician ZHEIMER'S DEMENTIA /Medical Immadiata Causa (Final disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer deeth.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit Sequantially list conditions, if any, leading to immadiata cause. Enter Undarlying Causa (Disaasa or Injury thet Initieted events rasulting in daath) Last Dua to (or as a consequance of): Box 68760, Physician/Medical Dua to (or as a consequence of) P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? ART URONARY 1 Yes 28 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy narformed? 1 Tas 2 No 1 Yas 2 No Division of Vital 25. Was casa refarrad to medical axaminar? Be 26. Pleca of Daath (Chack only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatlent 3 ☐ DOA Othar: 4₺ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 2 1 ☐ Yas 2 No 27. Mannar of Daath Date of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? 5 Panding Invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datamined 3 Suicide 28f. Location (Straet and Number or Rural Routa Number, City or Town, Stete) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 ☐ Homicide 18 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, end due to the ceuse(s) and mannar as statad.

2 Medical Examinar: On the basis of axamination end/or invastigation, in my opinion, death occurred at the tima, data and placa, and due to the ceuse(s) and mannar stated. Medical 29a. Certifian (Check only one) 29b. Signatura and titla of certifiar 29c. Licansa numbar 29d. Data signed (Month, Day, Year) 52740 mexine 30. Nema and address of person who completed causa of death (Itam 23a) (Type, Print)
ERNESTINE WRIGHT, COPPER RIDGE, 710, Object Road, SHKESVILLE, MD 21784 31. Date filad (Month, Day, Year) 32. Ragistrar's Signatura State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item: 19a per F.H G-769 3/26/99 reb 1. Decedent'a Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Day Charles Bielas Ki 10:00 AM MAR 16 4a Facility Nama (If not Institution, giva straet and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Solder SPRING Holy CRUSS Hus pital MONT 90 MERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Sacurity Number 6. Sex 1 XM 2 ☐ F Birth Day, Year) 11, 1927 of Columbia 7. Age (In yrs. last birthday) Yrs. 577-30-2075 Usual Rasidance of Dacedani 10a. Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☐ No Maryland Howard Elkridge 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Code 21075 517 Tufts Street USA 12. Was Dacedant Evar in U,S. Armed Forcas? 13. Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indian, Black, Whita, atc. 1V Yas 2 No If Yas, Giva Yaer or Datas: 1 Navar Marriad 2 Married 1 Yas 2 No Specify: WWII 3 Widowad 4 Divorced White 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/industry 15. Decadant's Education (Spacify only highest grade complated) Washington DC Elemantery/Secondary (0-12) Collega (1-4or 5+) Police Department Police Officer 18. Mothar's Nama (First, Middla, Maiden Sumema) 17. Fethar's Nama (First, Middla, Last) James Oscar Bielaski Katherine Wise 19a. Informent's Name/Ralationship (Type, Print) CHERYL 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Steta, Zip Coda) 6512 Baja Way Elkridge, MD 21075 Ann Shipe / Daughter 20b. Placa of Disposition (Nama of cematary, crametory or other place) 20c. Location - City or Town, Stata 20e. Mathod of Disposition 1 ☐ Burial 2 Oramation 3 ☐ Ramovel from Stata Metro Crematory, Inc. 4 Donation 5 Other (Specify) 3/18/99 Baltimore, MD Cremation Society of Maryland, Inc. nchemale Dawn F Cremation Society of Man 299 Frederick Road Balt 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 299 Frederick Road Baltimore, MD 21228 Approximate Intarval Batween Onsat and Death BRAIN StEM STROKE Immediata Cause (Final diseasa or condition resulting in death) 12 000 AtxIAL VIBRILLA HON Dua to (or es e consequence of): Sequentially list conditions, if any, laading to immadiata causa. Entar Undarfying Causa (Diseesa or Injury thet initiated avants rasulting in death) Last DILATER CAROLO MYOPAThy Dua to for as a consequence of: 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Aute INFERIOR MYOCARDIAL INFARCTION 24b. Were autopsy findings evailabla prior to completion of causa of death? 24a. Was an autopsy performed? 2 1 No 1 ☐ Yas 2 ☐ No 26. Pleca of Deeth (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Funeral

Director

with the Meryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Merylan Department of Health and Mentel Hygiene.
Important: If Item 27 is marked other than "naturel", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Enteriner must be notified an once.

altimore, Maryland 21215-0020

attending physician and for use as the burial-transit 88 page 2 s director, this

P.O. Box 68760.

Division of Vital Records,

Examiner Physician/Medical 10 funeral Certification: After after death. 24 hours

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i.

25. Was case referred to medical axaminar? 1 Yas 2 No 27. Mannar of Death

5 Panding Invastigation

6 Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Tima of

28a. Placa of injury - At homa, farm, straat, factory, offica building, atc. (Specify)

Hospital: 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA 28c. Injury et Work?

1 Yas 2 No

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

28d. Dascribe how Injury occurred

29a. Cartifian (Check only one)

1X Natural

2 Accident

3 Suicide

4 Homlcida

Certifying Physician: To the best of my knowledge, death occurred at tha time, data and place, and due to the ceuse(s) end mannar as stated.

Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated.

29b. Signature anti title of dentiller

29c. Licansa number D25080 29d. Data signed (Month, Day, Year) march 17 1499

30. Neme and eddrass of person who complated causa of daath (Itam 23e) (Type, Print) Georgia Are Silver Spring MV 20402

MA FLANK GRAVINO 31. Data filed (Month, Day, Year)

10313

32. Registrar's Signeture

Registrar

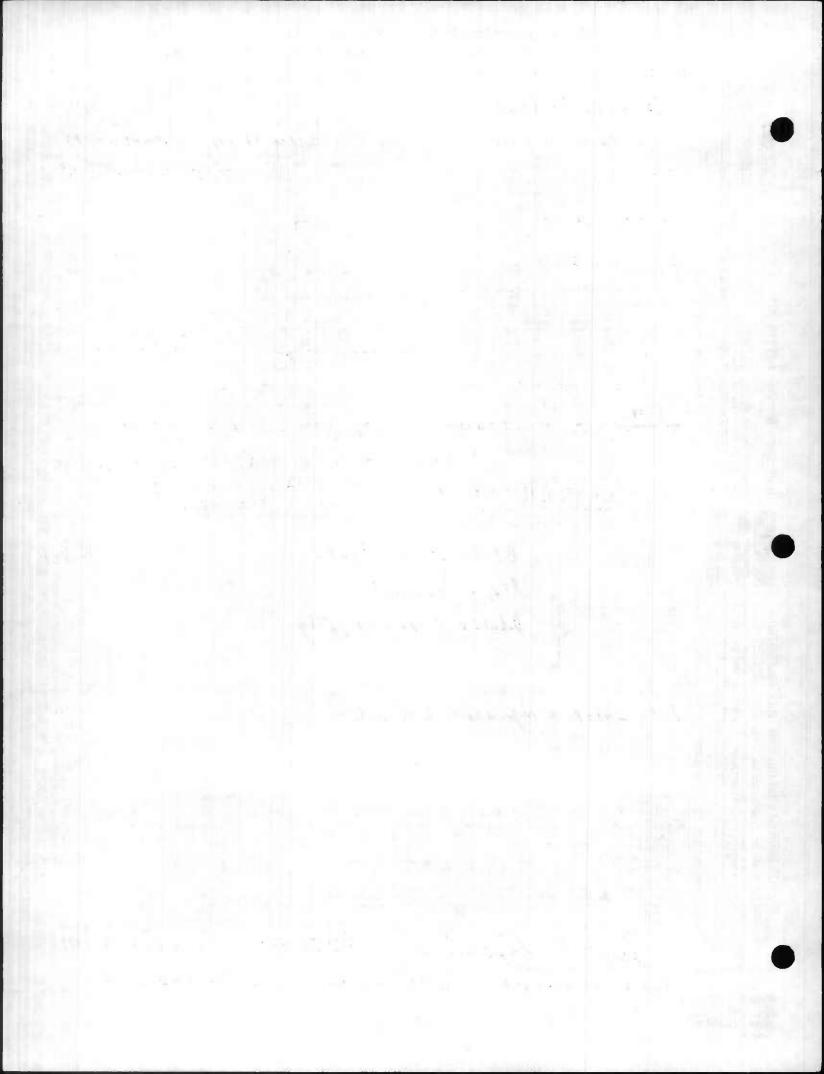
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1 9 1999

DHMH 16 Rev 6/95

within 24 hou To the Fune completely fi

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** BROWN CLAYTON 5. 3-00 PM 15 - 1999 MARCH /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BAT WORE

If Under 24 Hrs.
Hours Min.

8. Dete of Birth
(Month, Day, Year) MEDICAL VIS3 3 di CENTER TAUTIMORE If Under 1 Yeer 9. Birthplece (State or Poreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) **Funeral** Months Deys 1 M 2□ F 218-44-7710 53 Yrs Director Usuel Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pagas 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hydene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, its Modical Examiner must be notified a once. Baltimore 1 Yes 2 No NA Director Md 10e. Street end Numbar 10f. Zip Code 10g. Citizen of What Country? 21216 indson Avenue . S. A Funeral 12. Wes Decedent Ever In U,S. Amped Forces?

1 Yes 2 No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Married 2 Merried altimore, Maryland 21215-0020 1□ Yes 2 No Specity: Black Specify: þ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Fire Fighter Fire Department 12th grade 2 years 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Brown Joseph Stanley irginia 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Son Shoshone Way Brown 9971 Randall stown. 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Burial 2 Cremetion 3 Removel from Stete Cemetery 3-20-99 Anne Arundes Co, Md 4 □ Donetion 5 □ Other (Specify) Calvary 21. Signatura de Funerei Service Licensee 22. Name and Address of Facility.
March F. H. Woot
4300 Walash Avenue Baltimore red 21215 umppor if the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, leart fellure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician Accident Cerebro-varialar Immediete Ceuse (Finel diseese or condition resulting in deeth) /Medical Examiner Due to (or es a consequence of): Encephalopath-Examiner Anotic physician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or es e consequence of). Cardiomyopathi Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequenca of): 136 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were autopsy findings avellable prior to completion of cause of deeth? 24a. Wes an eutopsy 1 ☐ Yes 2 ☐ No 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 □ ER/Outpetient 3 □ DOA funaral 27. Manner of Deeth 26a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: or Attending 1 ENetural 5 Pending investigation after death. Director: Aft 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital or To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete and piece, and due to the cause(s) end menner stated. 29e. Certifler Medical (Check only one) 29b. Signeture end title of certifier 29d. Dete signed (Month, Day, Year) MAIZCH - 1- 3hal -)

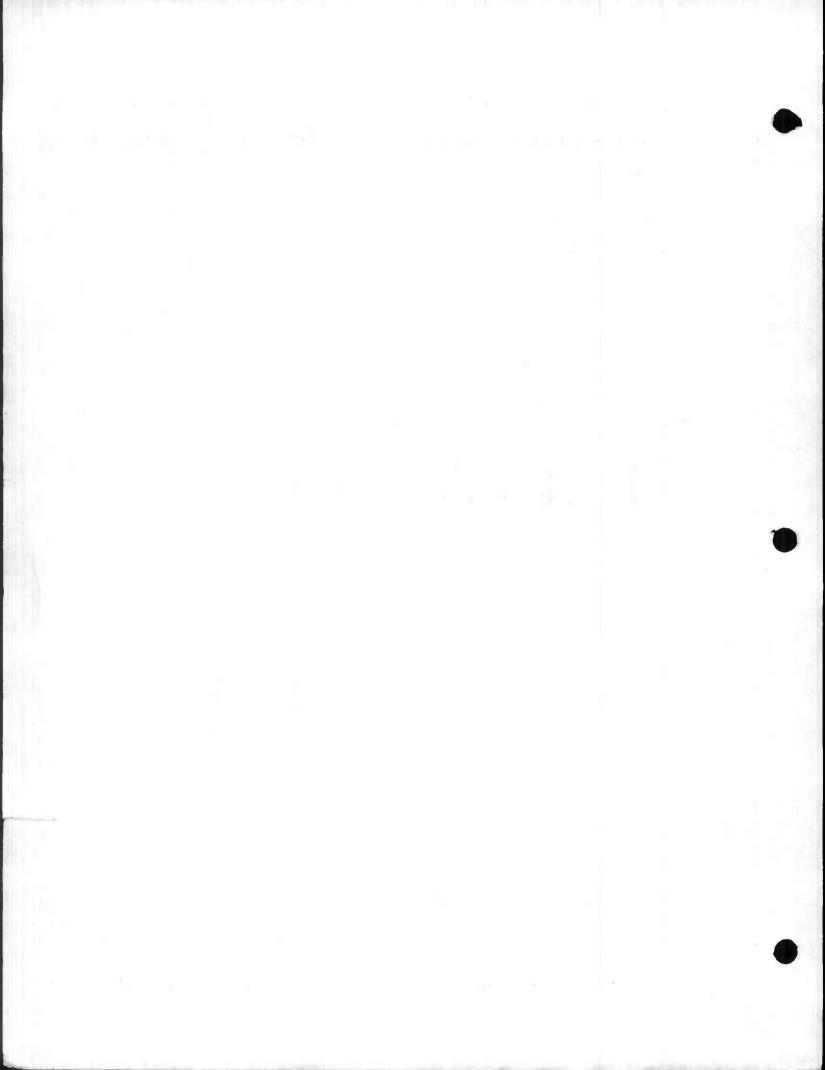
R. M. SHAH . LIBERTY HEDRAL CENTER 2600 LIBERTY HEIGHTS WE BALTO, MD 21215

State Registrar 31. Dete filed (Month, Dey, Year)

191999

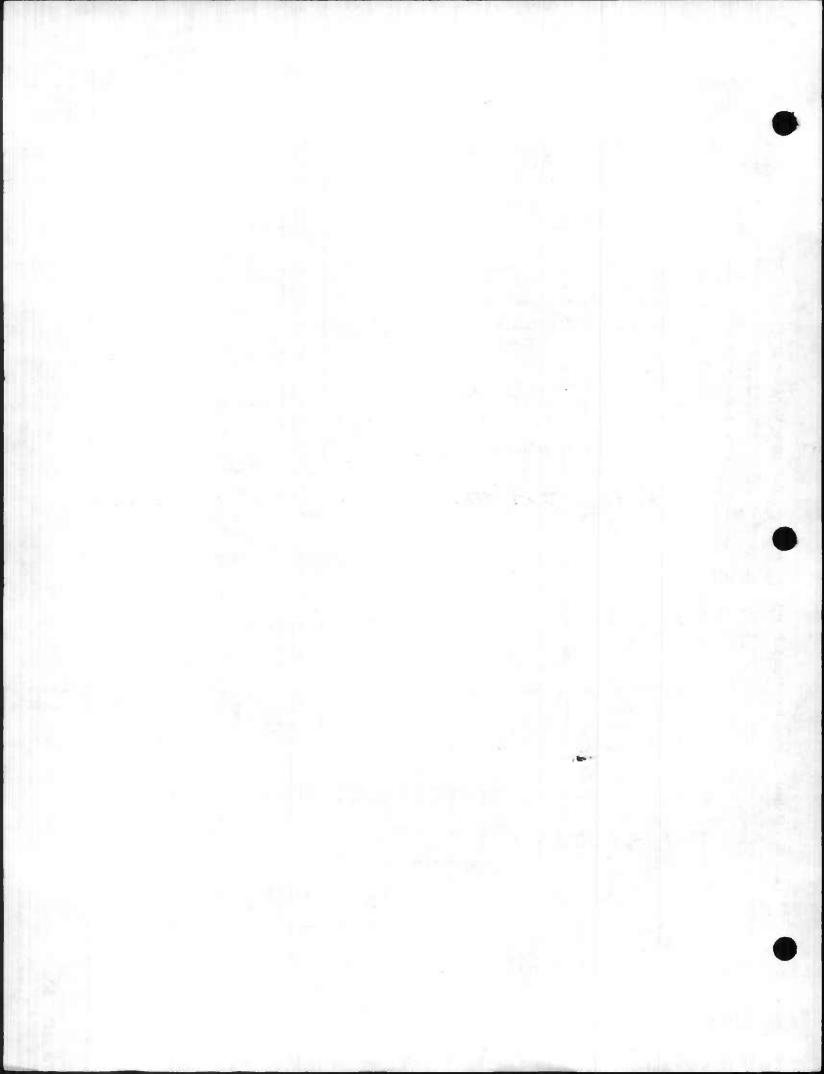
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene q 0 1 4

						Certifica	te of	Death		Reg. No.	0.0	יוכו	Ŷ
		1. Decedent's Name (First, M	liddle, Last)	EXE					2. Date of De Month		Vasa	3. Time of	Death
	Physician /Medical	Raymond I	•	Bathga	te				03	Dey 15	1999	5:40	pm
	Examiner	4a Facility Name (If not instit	ution, give street	and number)				4b. City, Town, o	r Location of Death	4c. County	of Death		
		1302 Ashbur	ton Cour	t				Millersv		Anne	Arun	de1	
	Funeral Director	5. Social Security Number 219–28–8059	6. Sex	OF	(In yrs. last bir	Yrs. If Und Months	er 1 Year Days			th y, Year) ,1932	9. Birthple Count Mary	ace (State of ry) land	x Foreign
2	*	Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location									1.0	44 14 0	to 4 7 to
aryle	of a P										10	xd. Inside Ci 1 ☐ Yes	
5	be notified be notified Director		e Arunde	;T	MILI	ersvill							X
deeth with the Marylend											What Count	ry7	
21215-0020 d within 72 hours after de-	5	11. Marital Status 1 □ Never Married 2/□ 1 3 □ Widowed 4 □ Divol	Married Ar	as Decedent E med Forces? ☑ Yes 2 ☐ N Yes, Give par or Dates:]	lo	13. Was Dec If Yes, sp	ecify Cub	an, Mexican, Pue	Specify Yes or No rto Rican, etc.)		ce - America ck, White, e		
5-0 72 h	natural.		dent's Education ghest grade com		16a.	Decedent's Us	ual Occup	pation	orkina	16b. Kind of B	usiness/Ind	ustry	
vithin	ygiene. Ner than "naturn rt, tre Medical Completed	Elementary/Secondary (0-1		ollege (1-4or 5-				during most of w d)		9			
	other trees.	12			In	strumen	tati	on Super		Chemica		nt	
Maryland	2 72 A	17. Father's Neme (First, Mid							ame (First, Middle,	Maiden Sumar	na)		
Should	Mente arked To E	Clarence W.							Taylor				
Mai 12 st	ls m	19a. Informant's Name/Relat							Rural Route Numbe				
C :	m 27 her tr	W. Joyce Ba 20a. Method of Disposition	thgate (Wife)		02 Ashb		n Court,	Millers				
E 6	Department of Hear moortant: If from 2 my Injury or other 2008.	1 Burial 2 Cramati 4 Donation 5 Othe		al from State	cemeter	y, crematory or Cremat	other pla		03/19	20c. Location Baltim			
Balt Permit.	Department Important: any Injury police.	21. Signature of Funeral Serv	rice Licensee	Kutt	5	Har	dest	ess of Facility Y Funera ely Aven	1 Home,	P.A.	MD 214	401	
		23a. Part1. Enter the disease shock, or haart failure.	, or complication List only one cau	s that caused sa on each lin	the death. Do r							Approximate Interval Beh	18 1W990
///	ysician Medical aminer	Immediate Cause (Final disease or condition		Athe	roal	noté	1.	leart	Direa	re		1982	Death
	100	resulting In death)	a	1	Dua to (or as a c			e Cal	lim			1996	0
D, axecuted	s the buriel-fransit	Sequentially list conditions, if any, laading to immediate cause. Enter Underlying										1982	
68760, ficate be a	ng physicis s as the bu	Cause (Disaese or Injury that initiated evants resulting in death) Last C. Due to (or as a consequence of): ONE OF THE CONTRACTOR OF THE							Entrue 198			198:	2
Box sath cent	use s		d	0040	ume	6	-cev	9 9	nune			1 10	
C Second	of for	Part II. Other significant cond	ditions contribution	ng to death bu	t not resulting Ir	the underlying	causa di	ven in Part I	23b. Did 1	lobacco use co	ntribute to	the cause (of death?
ords, P.O. Box 6876(requires that the death certificate be	hed by the detache	Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. — The Hall Valve wellevent								1 Yes 2 No 3 Probably 4 Unknown			
Division of Vital Records, P.O. Box or attending Physicien: The lew requires that the death ce after death. Director: After this certificate has been signed by the attendit in by the funeral director, page 2 should be deteched for use	page 2 should be detached for use page 2 should be detached for use completed by Physician/I	- Trabeles mellitus								24a. Was an autopsy performed? 24b. Were autopsy available prior completion of of death?			to
I Rec	e has age 2	11 400 100							101	res 200 No		Yes 200	No
ta :	certificate irector, pag	25. Was case referred to med	lical					OC Place of D		/		165 244	, 140
of Vita	his certifi. Il director To Be	examiner?	Hospita	II: 1 Inpatier	nt 2 ER/Ou	tpatient 3 🗆 🗈	Ot Ot	hor	Home 5 Resid		ner (Cassib	1	
P of	eral di	27. Magner of Death	288	. Date of Injun (Month, Day		ime of	28c. Inju Wo	4 🗆 Ivuising	28d. Describe			,	
O Bull	fun a fun	1 Natural 5 Per	nding estigation	(Month, Day	Year) I	njury M		rk?]Yes 2∐No	lo				
Division	d in by the	3 Suicide 6 Could not be determined 28a. Place of Injury - At home, tarm, street, factory, office building, atc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To the Hospital	Medical Certification: To Be Com	29a. Certifier (Check only one) 1 Certifier 2 Medi	cal Examiner: Or	To the best of the basis of and manner state	examination and	, death occurre d/or investigatio	d at the ti n, in my d	me, date and plac opinion, death occ	e, and due to the curred at the time,	cause(s) and m data and place,	anner as sta and due to	ited. the cause(s	5)
Total	N SO	29b. Signature and titla of cer	tifier		-	, 2	9c. Licens	se number		29d. Data signe	ed (Month, E	lay, Year)	
12.0	Va	Dalmae	in Di	man	Rein	ne	00	003891	2	03 -	llo-	99	
(NIV	30. Name and addrass of pars	on who complete	ed causa of da	ath (Item 23a) (Type, Print)	-	1 /.	, C.				1. ;
	1	SALVAGON	Dupac	n Ren	miner	1721	OCV	air the	hway sh	1 Le 202	Nein	2101	61
Į.	State	31. Date filed (Month, Day, Ye	ear)	32. Registre	r's Signature				1				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day 18, 1999 MORCH **Physician** Florence Baron 1:15 A.M /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Baltimore Saint Joseph Medical Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Une 19, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 135-09-3886 1 □ M 2 🛛 F 81 Yrs. Wilmington, Del Director Pages 1 and 2 should be filed within 72 hours after death with the Manyland neal of Haalth and Mentel Hygiene.
neat of Haalth and Mentel Hygiene.
neat I fam z 7 is marked other than "natural", or items 23a or 28a-f show mit. If item 27 is marked other than "natural", or other traumatic event, the Medical Experimes must be notified at my or other traumatic event, the Medical Experimes. 10a. State 10c. City, Town or Location 10d. Inside City Limits Hygiene. statural, or items 23a or 28a-f show ont, the Medical Examine, must be notified at 1 ☐ Yes 2 No Director Md. Baltimore Towson 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 409 Virginia Ave. Funeral 21286 14. Hace - American Indian 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0020 Specify: py 3 Divorced 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementary/Secondary (0-12) College (1-4or 5+) 8 Bookkeeper Banking 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be Joseph DeJianne Theresa Riordan 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 121 Rockrimmon Road Reisterstown, Md. Phyllis Mandara - daughter 20b. Placa of Disposition (Name of 20c. Location - City or Town, State Date 20e. Method of Disposition cemetery, crematory or other place) 1 ☐ Buriat 2 🛣 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metro Crematory March 19, 1999 Baltimore, Md. 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Ell Eckhardt Funeral Chapel 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ings. Mills approximate shock, or heart failure. List only one cause on each line. Physician SEPSIS /Medical Immediate Cause (Final disease or condition resulting In death) Examiner Due to (or as a consequence of): Examiner ettending physician and for use as the burial-transit The law requires that tha death certificeta be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of) signed by the e Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 5 Unknown PROGRESSIVE RENAL FAILURE Š 24b. Were eutopsy findings evelleble prior to completion of cause of death? been si 24a. Wes en eutopsy performed? Completed is certificate has director, page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 28b. Time of 28d. Describe how Injury occurred After 5 Pending daath. 1 ☐ Yes 2 ☐ No investigation after daath Director: A d in by the f 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end manner steted. 29a. Certifier edical (Check only one) 8 To the within 2 To the complet 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 37254 3-18-90 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)
BOON P. LIM, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State MAR 19 1999

DHMH 16 Rev 6/95

Registrar

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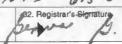
State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth 500 **Physician** Alice Frances Beckelheimer 03 pm /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Harford Mariner Health of Bel Air Bel Air | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | Feb. 26, 1917 Birthplace (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs, lest birthday) **Funeral** Months 1□ M 2√2 F 82 Yrs. 250-07-9767 South Carolina Director Usual Residence of Decedent the Maryland 10d Inside City Limits 10e. State 10h County 10c. City. Town or Location f is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at Maryland Harford Bel Air 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21014 U.S.A. 410 E. MacPhail Road Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Specify: White 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Hygiene. Speech Pathologist School 18. Mother's Name (First, Middle, Malden Sumeme) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be 1 Department of Haeith end Mantal I Important: If Item 27 is marked oth any Injury or other traumatic even once. 2 should be fi end Mantal H Sarah Ellen Pearson Arch Francis Beckelheimer, Sr. 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1617 S. Tollgate Road, Bel Air, Maryland 21015 Robert Beckelheimer/brother 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade Director 22 Name and Address of Facility Board, 655 W. Baltimroe Street Baltimore, Maryland 21201 Approximete Interval Between Onset end Death rt1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such es cardiac or respiretory arrest, lock, or heert failure. List only one ceuse on each line. **Physician** Cornary Arteny Disease /Medical Immediate Cause (Final disease or condition resulting in deeth) URARS Examiner Due to (or as a consequence of):

CHronic Pulmonony Fobrosos Examiner ician and bunal-transit the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last Due to (or es e consequence of): physician at the bunal Physician/Medical Due to (or es e consequence of). 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t 1 Yes 2 No 3 Probably 4 Minknown g 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an eutopsy Completed peen ; 1 Yes 2 No this certificate has 1 Yes 2 No 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) 200 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes funeral 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 28a. Date of Injury (Month, Dev Year) it or Attending Ph after death. 1 Natural 2 Accident 5 Pending NA 1 Yes 2 No investigation NA 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital of 24 hours a
 Funeral D 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner as stated.

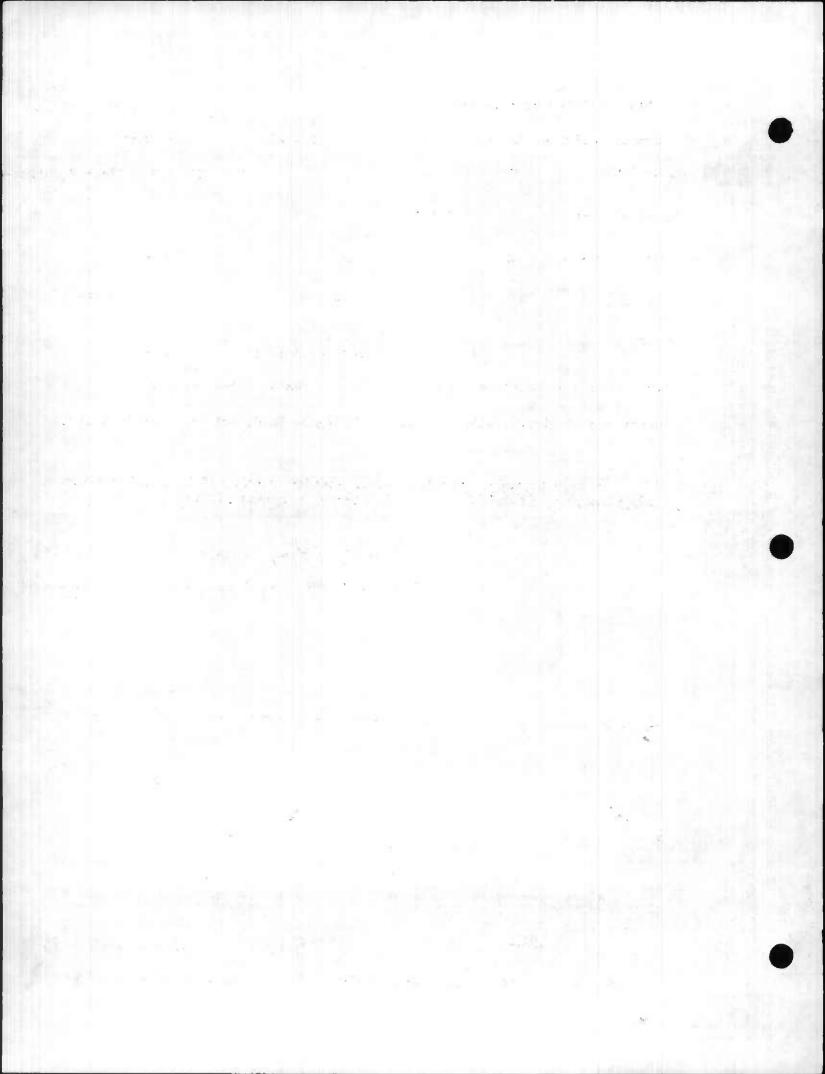
2 Medical Examiner: On the best of exeminetion end/or investigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) end manner stated. Medical To the Hosp within 24 ho To the Fune 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture end title of certifier MARCH 13th 1889 497 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. MACATAIL RD BURIN NO 21014 MERKO SPANIS

State Registrar 31. Date filed (Month, Dey, Year)

MAR 1 9 1999



for des



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3:06 pm February 1 TT1 Aaliyah Beavers 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Schare Hospita (enter 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1□M 2√2F none 22 Feb. 4, 10 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits Maryland Baltimore Baltimore County 1 ☐ Yes 2 ☑ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1233 South Marlyn Avenue 21221 U.S.A. Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none none none 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Valorie Corner Roderick Beavers 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1233 S. Marlyn Avenue, Baltimore, Maryland 21221 Valorie Corner 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ☑ Other (Specify)in state 21. Signature of Funerel Service Licenseede, Director 22 State Affato My Board, 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final Ischemic Encephalopathy Zdays 21 hour disease or condition resulting in death) Due tolor as a consequence of): Abruption Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No

26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Stete

Directo

Funeral

py

Completed

Be

Funeral

Director

945

If item 27 is marked other than "natural", or items 23s or 28s-1 show or other traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer. Department of Health and Mentel Hygiena. Important: If flem 27 is marked other than "natural", or fer any injury or other traumatic event.

Seavers, Aaliyah

Examine

attending physician and for use as the burial-transit peen s has To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifical completely filled in by the funeral director.

Physician/Medical Be 2

Completed by edical Certification:

25. Was case referred to medical examiner?

29b. Signature and title of certifier

31. Data filed (Month, Day, Year)

5 Pending investigation

6 ☐ Could not be

Kottapalli

1 9 1999

1 Yas 2 No

27. Manner of Death

1 Natural 2 Accident

3 Suicida

29a. Certifier (Check only one)

V. Dita

4 T Homicide

the death certificate be asscuted Box 68760. P.O. Division of Vital Records,

> State Registrar

DHMH 16 Rev 6/95

Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA

28b. Time of

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

140 Herran 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrer's Signature

28c. Injury at Work?

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

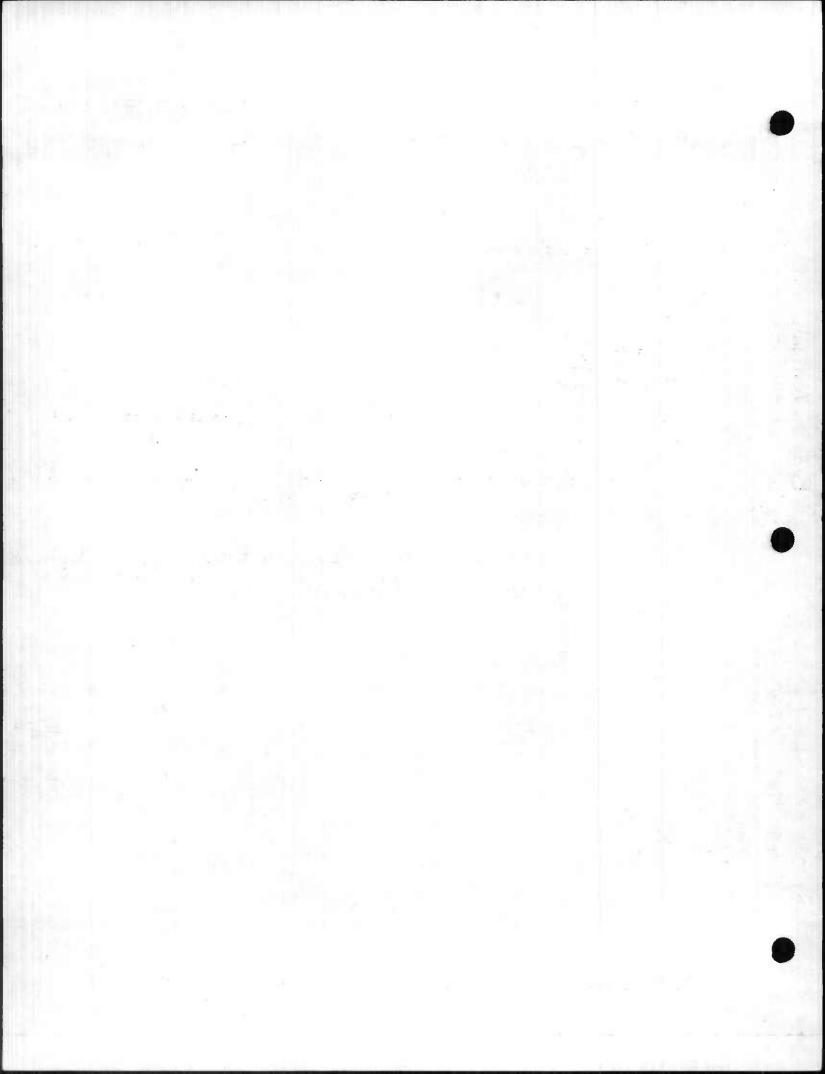
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 22511

9000 Franklin Square Drive, Baltimore, MD 21287

1 ☐ Yes 2 ☐ No

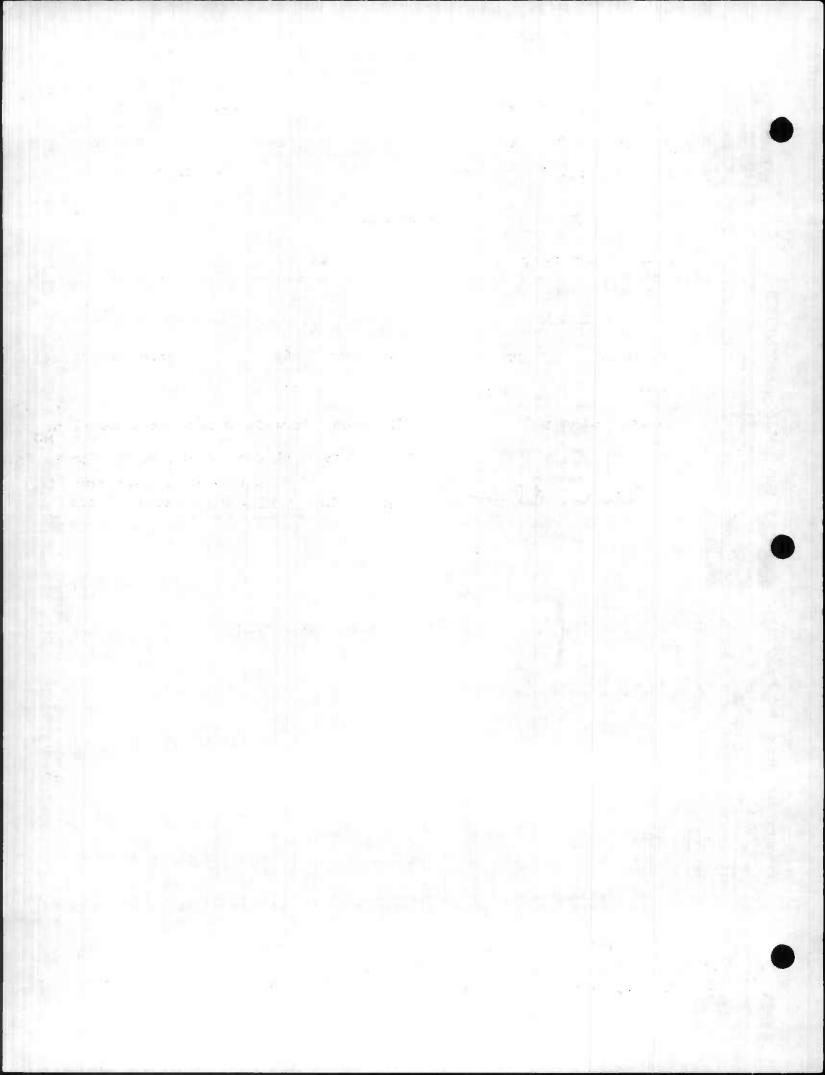


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 189 8

	Decedent's Name (First, Middle, L.)	ast)		Certifica	ate of	Death	2. Date of Dea	Reg. No.		3. Time of Deat
Physician-	Roy T	Cleary					Month March	Day	Year 99	12:25
/Medical Examiner	4a Facility Name (If not institution, g					4b. City, Town, or I		_		
LAMITHE	St. Joseph Ho	spital				Towsor	1	Ba	ltimo	ore
Funeral Director	5. Social Security Number 6. 230-22-6874A	Sex 7. Ag	e (In yrs. last	birthday) If Unc Yrs. Month	der 1 Year ns Deys		8. Date of Birt (Month, Da) 05-08	h v. Year)		ce (State or Form
pue M	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Location					100	d. Inside City Lin
f sho	MD NA		Bal	Ltimore						1 ☑ Yes 2 □
vith the Mer	10e. Street and Number				Zip Code			10g. Citizen of V	/het Countr	v?
With Name	1729 N. Broad	1.7 3 17		377	2121	2		USA		
a within 72 hours after deeth with the Meryland spiene. It han "naturet", or from 23a or 28a-f show the Medical Exertines must be notified a completed by Funeral Director.	11. Marital Status 1 Mever Merried 2 Married	12. Wes Decedent Armed Forces? 12 Yes 2 1	Ever in U,S.	13. Wes Dec If Yes, s		Hispenic Origin? (S ean, Mexicen, Puert	pecify Yes or No- o Rican, etc.)		e - Americar k, White, et	
urat', o	3 Widowed 4 Divorced	Yeer or Dates:							Bla	
nath dea	15. Decedent's (Specify only highest g	Education rade completed)	10	6a. Decedent's U: (Give kind of	sual Occu work done	pation during most of wor ed)	king	16b. Kind of Bu	sinass/Indu	stry
P 5 - 0	Elementary/Secondary (0-12) 3rd Grade 17. Father's Name (First, Middle, Las	College (1-4or 5	+)			Repair	ne (First, Middle,	North Maiden Sumam		tSteel
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d 2 should be filed th and Mental Hygi 7 is marked other traumatic event, To Be Co	Roy 19a. tnformant's Name/Relationship	Cleary (Type, Print)	1	9b. Mailing Addre	ess /Stree	t and Number or Ru	ral Route Number			Code) 212
	Walter Clear					Farm R				
ges 1 and 2 tof Health if Hem 27 lor other tri	20a. Method of Disposition	1	20b. Place	of Disposition (A	Vame of		Date			m, State MD
Pa Liv	N☐ Burial 2 ☐ Cremation 3 4 ☐ Donetion 5 ☐ Other (Spec	eity)	Gar		Fore	st VA C			_	
permit. Depertrumports any inju	21. Signature of Funeral Service Lice	Elmon	P			ess of Fecility E erch FH	Baltimo		-	
Physician .	23a. Part 1. Enter the disease, or co shock, or heart failure. List onl	mplications that caused y one cause on each li	the death. D	o not enter the m	node of dy	ing, such as cerdiad	or respiratory en	rest,		Approximate nterval Between Onset end Deeth
/Medical Examiner	tmmediate Ceuse (Finel disease or condition resulting in death)	e	epsis	a consequence of	-4\-				1	Ink
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executed n end isl-transit Examiner	Sequentially list conditions.	b		a consequence of	of):					
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eath certificate be executed attending physician end for use es the burial-transit clan/Medical Examír	that initiated events resulting in death) Last			e consequence o						
d for	Part II. Other significant conditions	ontributing to death but not resulting In the underlying ceuse give			given In Part I. 23b. Did tobacco use contr				the causa of de	
that the death cert ed by the attendin detached for use		contributing to doubt b	a not rooutin	g III lilo dilidoliyii.	g occor gi	7011 11 1 4111.		Yes 2□No		
The law requires that the death cer sate hes been signed by the attendin page 2 should be detached for use Completed by Physician/N							24a. Was perfo	an autopsy rmed?	avali	e eutopsy findin lable prior to pletion of cause sath?
The law te hes sage 2							101	Yes 2-10	10	Yes 28 No
	25. Wes cese referred to medical					26. Place of Dec	ath (Check only o	one)		
nysici I direc	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie	nt 2 ER	Outpatient 3	DOA Ot	her: 4 Nursing H	lome 5 ☐ Resid	dence 6 Oth	er (Specify)	
leath. lor: After th the funeral cation: "	27. Manner of Deeth 1 ☑Naturel 5 ☐ Pending 2 ☐ Accident investigati	28e. Dete of tnju (Month, Da)	Year) 28	b. Time of Injury M	28c. Inju Wo	ry at ork?] Yes 2 □ No	28d. Describe I	how Injury occur	red	
tal or Attending Physician: The ster death. The funeral director, after this certificate of in by the funeral director, as Certification: To Be Co	3 Suicide 8 Could not 4 Homicide determine			, ferm, street, fact	lory, office		28f. Location (S City or Tov	Street and Numb wn, Stete)	er or Rural	Route Number,
	29a. Certifier 1 Certifying F	Physician: To the best of aminer: On the basis of and menner sta	examinetion	dge, death occurre end/or investigati	ed at the ti	ime, dete end plece opinion, deeth occu	e, end due to the arred at the time,	ceuse(s) and ma date end place,	nner es sta end due to t	ited. the ceuse(s)
Hospit 24 hour Funeraletely fills	(Check only 2 Medical Exit							29d. Date signe	d (Month, D	lav. Year)
To the Hospit within 24 hour To the Funera completely fill.						^	29d. Date signed (Month, Day, Year) 3-16-99 Balt md 2120			
he Hospi in 24 hou he Funer pletely fill edical	29b. Signature and title of certifier	o Kioung			•	031865	5	3-1	6-9	
To the Hospit within 24 hour to the Funers completely filling Medical (29b. Signature and title of certifier		eath (Item 23		(- 1	31865	5	3-1 Back	6-9	

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Caldas 10 apm. ose March 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Deeth Dital)altimore If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 10/14/18 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days 1DM 2□ F Hours 80 051 20 9566 Usual Residence of Decedent 10c. City Town or Location Station 10d. Inside City Limits Baltimore 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number USA 21222 410 Chestnut Ct. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status the roos of the roos of the root of the r 1 Never Married 2 Married 1 Yes 2 No Specify: Latin American 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Buainess/Industry Elementery/Secondary (0-12) College (1-4or 5+) U.S. Coastguard 12 Merchant Seaman 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) UNK UNK 19e. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto., Md 21222 Odessa Caldas/ Wife 410 Chestnut Ct. 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Dete 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/22/99 Crownsville V.A. Cem Crownsville, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility James A. Morton & Sons F.H., INC 23a. PARI. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last oronary Due to (or as e consequence 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of ceuse of death? 24a. Was an autopsy 1□ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 3 Suicide 4 Homicide

The law requires that the death certificate be executed attending physician and for usa as the bunal-transit Division of Vital Records, P.O. Box 68760. signed by the a Completed s certificate has t Hospital or Attending Physician: 24 hours after death. Funeral Director: Attar this certifical To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b

Physician /Medical

Examiner

Examiner

Physician/Medical

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Certification: To

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Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fram 27 is marked other than "natures", or items 23s or 28s-f show hijury or other traumatic event, the Medical Examinat Instit be not the page.

altimore, Maryland 21215-0020

281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and manner es stated.

2 Madical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signeture and title of certified

29c. License number 29d. Date signed (Month, Day, Year)

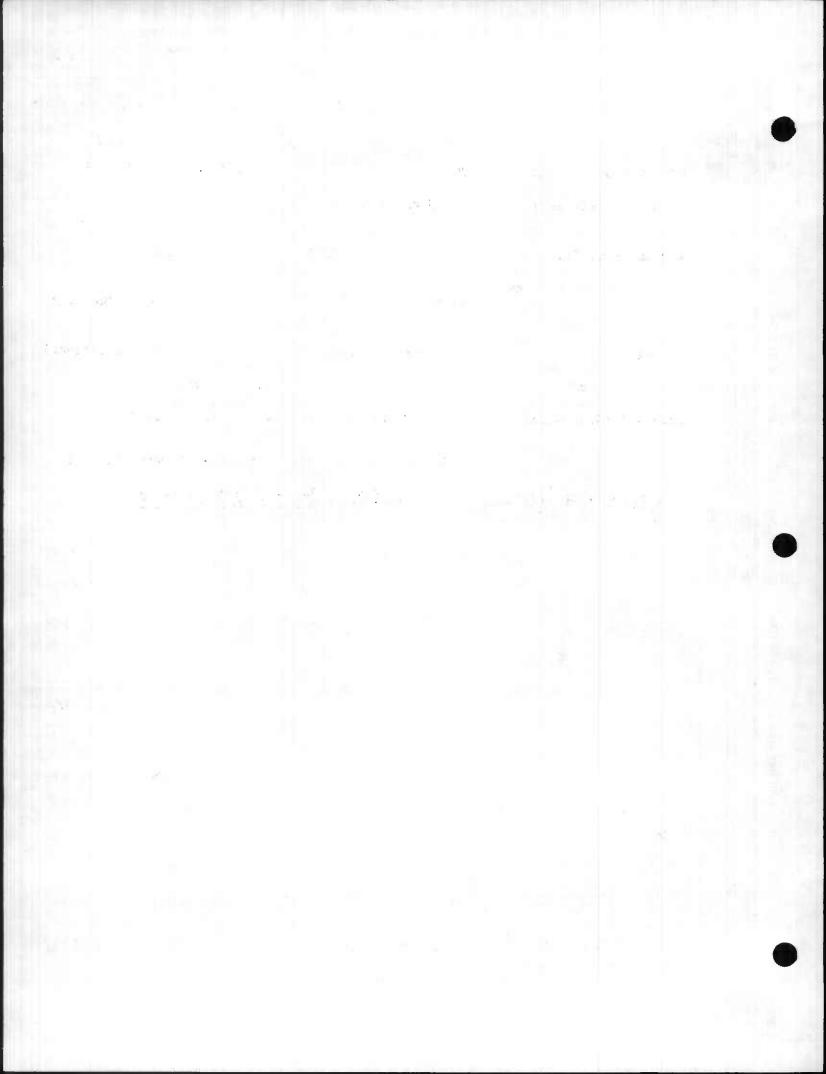
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

P. VIGILANCE - JOHNS HOPKINSHOSPITAL 31. Date filed (Month, Day, Year)

Registrar

32. Registrar's Signature

MAR 1 9 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, ITEM: #23 PART I, PER PHY G769 3-19-99 WR. Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Deeth 3. Tima of Death Yaar **Physician** 23:59 MARCH Hazel R. Clayton 1999 /Medical 4b. City, Town, or Location of Daath 4a Facility Nama (If not institution, giva straat and number) 4c. County of Death Examiner Harford Fallston General Hospital Fallston | H Undar 1 Year | If Undar 24 Hrs. | 8. Data of Birth (Month, Day, Year) | Hours | Min. | Mar. 23, 1910 Birthplaca (Stata or Foreign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** 10 M 20XF Yrs Kingsville, Maryland Director 213-01-9911 Usual Rasidance of Decedant 10b. County 10c. City. Town or Location 10d. Inside City Limits I show ir than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yas 2 No Directo Maryland Baltimore Kingsville 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Number 21087 U.S.A. 7100 New Cut Road Funeral 13. Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Dacedant Evar in U,S Armed Forcas? 11. Marital Status 1 Yas 2 No If Yas, Give Yaar or Datas: 1 Navar Married 2 Married 8 1 Yas 2 No Specify: Specify ð 3 N Widowed 4 Divorced "naturel", White Completed 16a. Dacadent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry al Hygiena. Elementary/Secondary (0-12) Coilege (1-4or 5+) 8 yrs. Seamstress Edgewood Arsenal n/a 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other treumstic event DRBs. Be George Williams Lydia Mast 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rurel Routa Number, City or Town, Stata, Zip Coda) 2802 Mountain Rd. Joppa, Md. 21085 Mr.Jon W.Clayton (Son) 20b. Placa of Disposition (Nema of camatary, crametory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Data 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 3/15/99 Fork, Maryland 21051 4 ☐ Donation 5 ☐ Othar (Specify) Fork Meth.Church Cem. 21. Signatura of Funarai Sarvice License 22. Nama and Address of Facility E.F.Lassahn Funeral Home 23a. Part1. Ente ssa 11750 Belair Road Kingsville, Md. 21087 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, at only one cause on each line. Approximata Intervel Between Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) **Examiner** consequanca of Examiner Colovescicle Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consaquance of) pue physician AORTIC STENOSIS, SEVERE Physician/Medical Dua to (or as a consaquance of) 2 screse 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. Ē 1 Yes 2 No 3 Probably Unknown bengis d be del by 24b. Wera autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy Completed 1 Yes 2 No 1 TYas 2 No 25. Was casa rafarrad to medicai 26. Place of Death (Check only ona) Be axaminar? Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA P 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No 2 Accidant invastigation if or Atten-after deaf Director: 3 Suicida 6 Could not be datarmined 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral I

with the Maryland

altimore, Maryland 21215-0020

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, deeth occurred at the tima, data and piace, and due to the cause(s) and mennar as steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar statad.

will tile of certifian

29c. Licansa number

MARCH 12, 1999

29d. Data signad (Month, Day, Year)

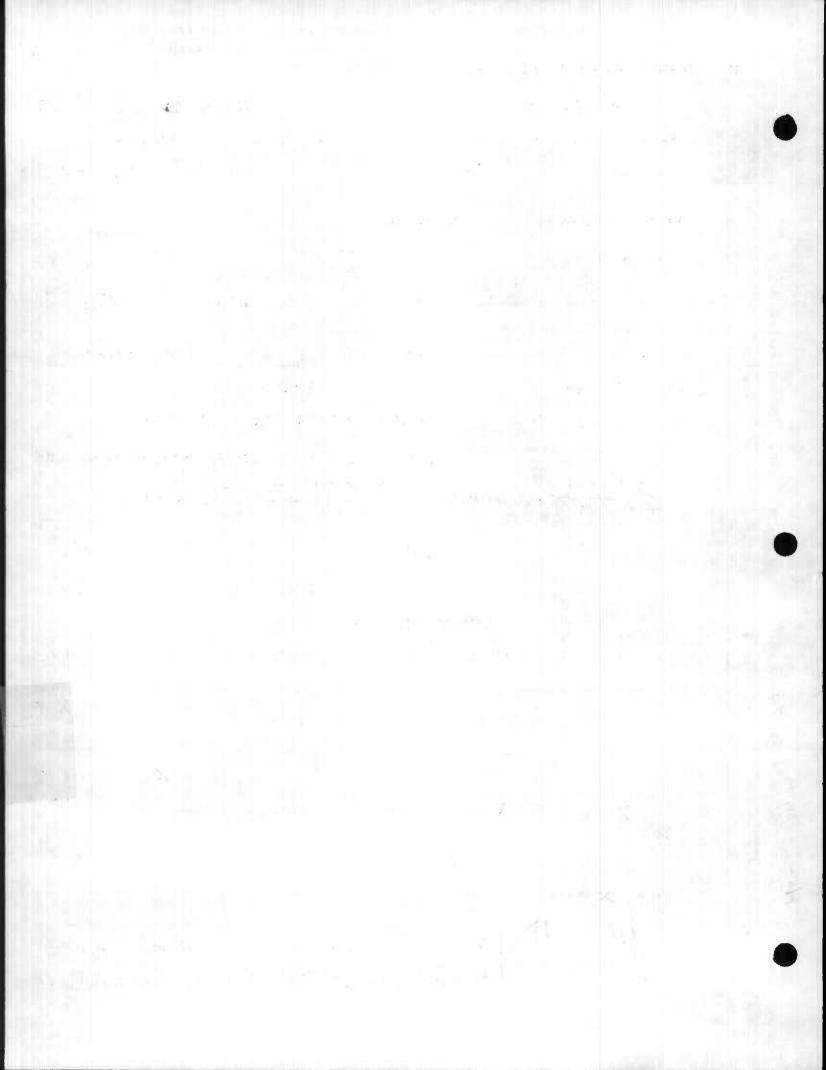
30. Neme and address of person who completed c use of death (Itam 23a) (Type, Print)

2 Colgate Drive Suite 101 Faver Hill, Md 21050 Steinmett MA 31. Date filed (Month, Dey, Yaar)

State Registrar

MAR 1 9 1999

32. Ragistrer's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

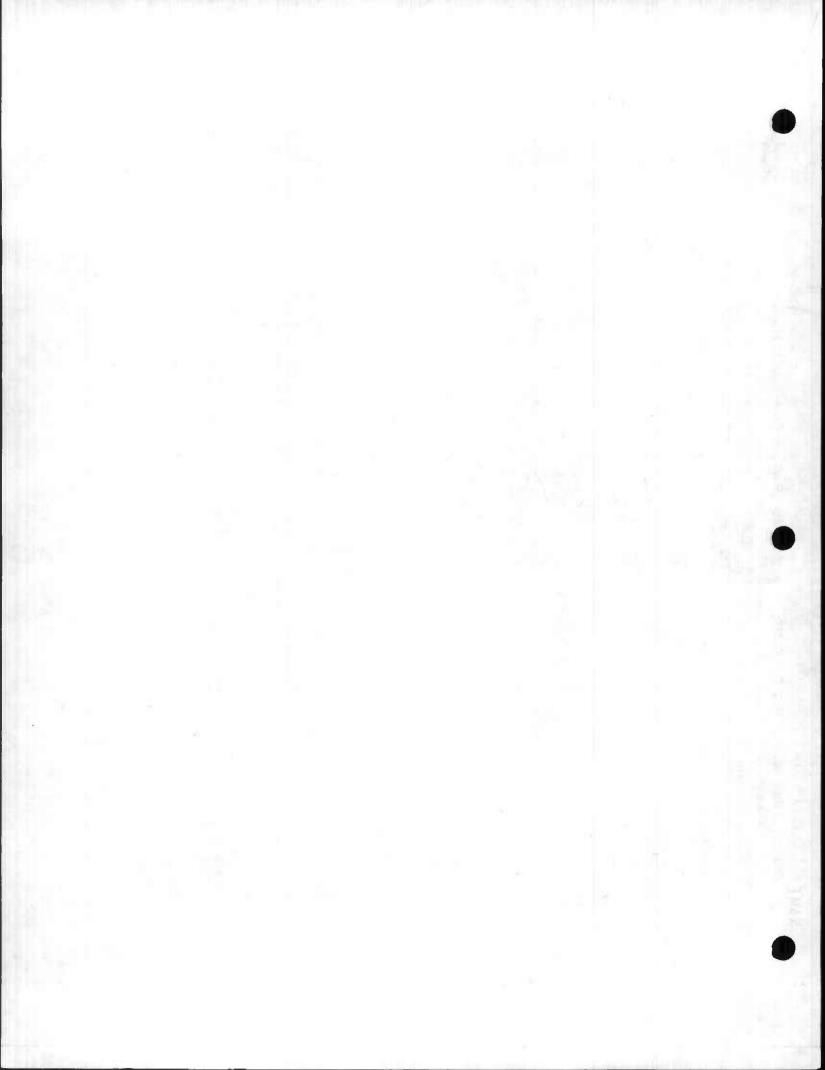
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month MARCH **Physician** Doris May Cornelius 0113 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL ST. AGNES BALTIMORE ff Under 1 Year If Under 24 Hrs. 8. Date of Birth North, Days Hours Min. NOV. 21, 1928 9. Birthplace (State or Foreign MI) 5. Social Security Number 7. Aga (In yrs. last birthday) Funeral 1 M 2 F 217-24-8426 70 Director Usual Residence of Decedent the Menyland 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits "netural", or items 23a or 28a-f ehow WV 1 ☐ Yas 2 No MOrgan Berkley Springs Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours effer death with i each of Health and Menial Hygiene.
Int: If Item 27 is marked other than fastural, or from 23a or intry or other transmitters. P. O. Box 694 25411 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14 Race - American Indian 11 Marital Status Black, Whita, atc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Rusinass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18 Mother's Name (First Middle Maiden Sumama) 17. Father's Nama (First, Middle, Last) Clarence GIddings Eleanor Souder 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mike Cornelius (Son) 305 Concert Way, Catonsville, MD 21228 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata permit. Page Depertment of important: if eny injury or patca. 3/20/99 Baltimore, Maryland Gardens of Faith 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Mann 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tntarval Between Onset and Death **Physician** CARDIOMYOPATHY /Medical Immediata Cause (Final disease or condition resulting in death) 10 YEARS Examiner Examiner physicien end the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 45 Unknown by 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 275 40 1 Yas 1 Yas 2 No Vital or Attending Physicien: 25. Was casa referred to medical examiner? 8 26. Place of Death (Check only ona) Hospitat: 150 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 27. Manner of Death 1 SNaturat 28b. Tima of 28d. Describe how injury occurred 28c. tnjury at Work? 28a. Data of Injury (Month, Day Year) 5 Pending efter deeth. 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 15d Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certified 29c. License number 29d. Data signed (Month, Day, Year) citica MEDICAL DOGOR 30. Nama and eddress of person who completed cause of death (Item 23a) (Type, Print) WORLAH NUTAKOR, ST. AGNES HOSPITAL, 900 CATON AVENUE, BALTIMORE, MARYLAND 21229 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State Registrar

DHMH 16 Rev 6/95

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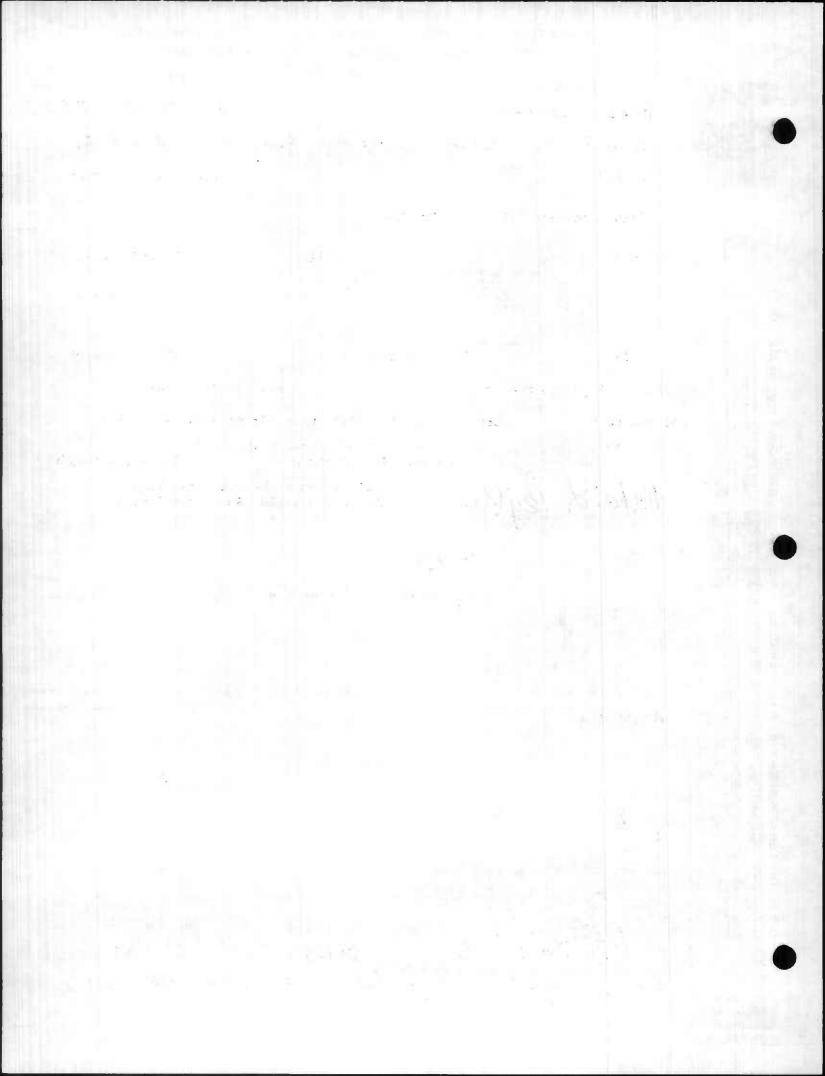
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Nama (First, Min	ddle, Last)	u se il	3071	ificate of		2. Data of Dea Month	th Day	Yaar 3.	Tima of Death
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aminer	4a Facility Nama (If not institu	tion, give street an	d number)	_		4b. City, Town, or Lo	ocation of Death	4c. County	of Death	
		rundel	Medical	Len	ec	Anny	1-115	Ann		
eral ctor	5. Social Security Number 259 10 4468 Usual Rasidanca of Dacedant	6. Sax 1 ☐ M 2 ☑	F 7. Aga (In yrs	last birthday) Yrs.	If Undar 1 Yaar Months Days	Hours Min.	8. Date of Birth (Month, Day Feb. 15		9. Birthplaca (Country) Georg	State or Foreign
15	10a. Steta 10b. Cou	nty	10c. C	ity, Town or Loca	ation				10d. tn	sida City Limits
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Funeral Director	10e. Street and Number				10f. Zip Coda		1	0g. Citizan of V	Vhat Country?	
<u>e</u>	1674 Carlyle	Drive			21	114		United	1 States	3
ner	11. Marital Status	12. Was	Decedent Evar in U	J,S. 13. W	as Decedant of H	lispanic Origin? (Sp an, Maxican, Puarto	ecity Yes or No- Rican, atc.)	14. Rac	e - Amarican Inc k, Whita, atc.	dian,
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Be Completed	15. Deced	dant's Education	ted)	16a. Deceda	nt's Usual Occup	oation during most of work d)	ing	16b. Kind of Bu	usinass/Industry	
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o Be	PEarson Augu		tor				ine M. I			
Ĕ	19a. Informant's Name/Ralation			19b. Mailing	Addrass (Straat	and Number or Rur			Stata, Zip Code	1)
2	Norman Corman		sband			Drive Cr				
OCUM	20a. Mathod of Disposition		20b.	Ptaca of Disposi	tion (Nama of	ce) March 1	Q Date QQQ	20c. Location -	City or Town, S	tata
o o	1 Burial 2 Cramatic		TUITI State		tan Cre		9, 1999	Alexand	iria Vi	rginia
any injury or other traumatic event, the Medical blice. To Be Completed	21. Signeture of Funarel Sarvi	cerLicansa	0			ass of Facility Evans Fun	eral Hor			
any injury or other traumatic event, the Medical Examples. To Be Completed by F	23a. Part1. Enter the disaasa shock, or heart failura. L	124	M	160	00 Anna	polis Rd.	Bowie N	Maryland		oximata
Ifor use es the buriel-transit Lan/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, teading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting in deeth) Lest	a b c	Dub to (or as a consequence as a consequence or a consequence or a consequence	Pine anca of):	umo n. q				
by Physician/A		d					00h D144		1	
hys	Part II. Other significant cond	ittions contributing	to death out not re	suring in the und	anying causa gr	ven in Pert I.		es 2□No	3 Probably	cause of death?
Medical Certification: To Be Completed by Physician/M	gementiq						24a. Was a	an autopsy mad?	available	utopsy findings a prior to ion of cause
Juc							1 D Y	as 25No		2 □ No
o. p	25. Wes case rafarrad to med	icai				26. Place of Deal		-		
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	29a. Certifier 1 Certific Check only 2 Medic	ying Physician: T cal Examiner: On t	o the best of my kn he basis of examin	owledge, deeth o	occurred et the ti estigetion, in my	me, date and placa, opinion, deeth occur	and dua to the cred at tha time, c	euse(s) and ma dete end plece,	annar es steted. and due to the	cause(s)
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ompietely fille	29b. Signatura and this A	man /						1 4		
completely filled in by the funeral director, page 2 should Medical Certification: To Be Completed	29b. Signatura and this programme	Xet.	T and		NDF	15277	7	3/17/	44	
completely fille	> Ceter	Service on who completed	July cause of death (Me	m 23a) /Tuna D	D DC	05327	7	3/17/	99	
completely fille Medical C	29b. Signatura and title of the state of the	on who completed	causa of death (Ite	m 23a) (Typa, P	DOE	15327°	polis	3/17/	49	13

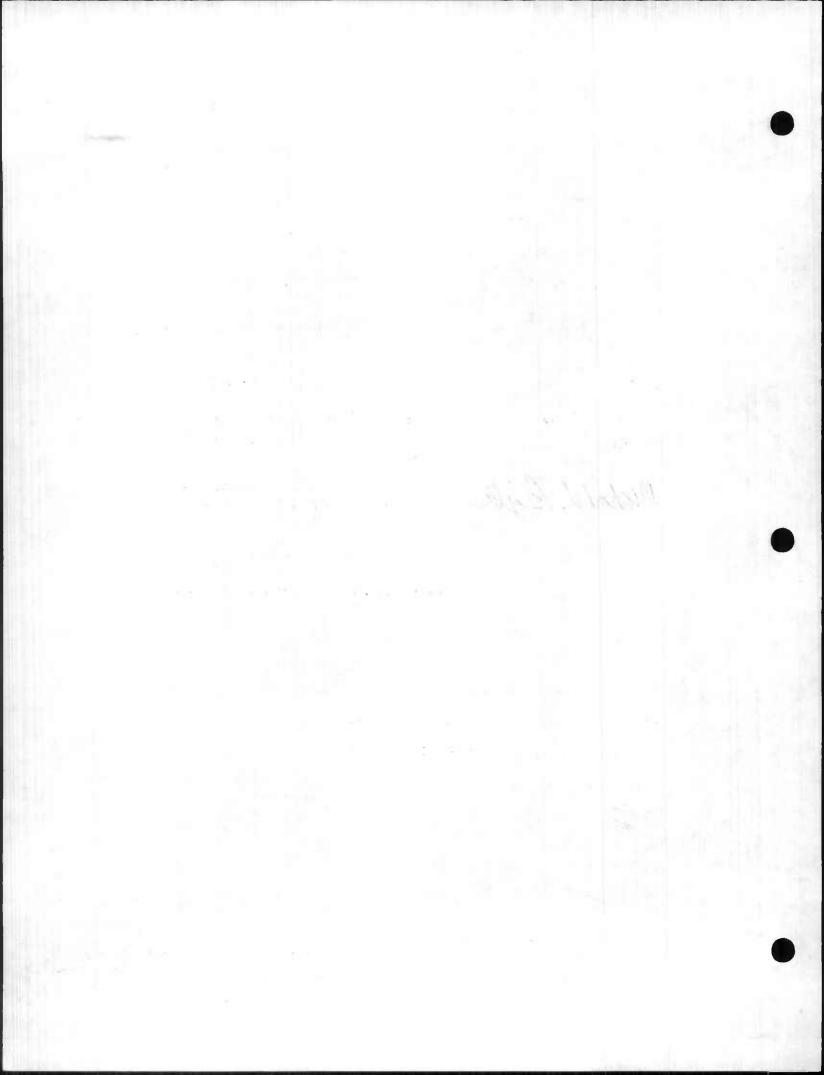
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State of Maryland / Department of Health and Mental Hygiene 9 9 3

		Certificate of Dea	th	Reg. No.	0760						
	Physician	1. Decedent's Nama (First, Middla, Last) Henry Paul Cooper	2. Data of De Month	Day Year	3. Time of Death 3:45 A.M.						
1	/Medical Examiner	•	March y, Town, or Location of Death								
	LAGITITICI	Anne Arundel Medical Center Ann	napolis	Anne Aru	ndel						
	Funeral Director	127 01 4875 1 ¹ M 2□ F 77 Yrs. Months Days Hou	urs Min. 8. Data of Bin (Month, Da Oct. 3	th Year) 9. Birth Cou 1, 1921 Ne	nplace (Stata or Foreign untry) W York						
	pue & s	Usual Rasidance of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Insida City Limits						
	Maryls fator	Maryland Anne Arundel Annapolis			1 ☐ Yas 2\\ No						
	vith the Ma t or 28s-f a be notified Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Cou	untry?						
	23a 23a rai D	2968 Southhaven Drive 21401		United State	es						
Maryland 21215-0020	illed within 72 hours after death with the Maryland Hygiene. Hygiene. With the Maryland Cambra 23a or 28a-f show mit, the Maryland Examinar mint be notified at a Completed by Funeral Director	3 ☐ Wildowed 4 ☐ Divorced Yaar or Dates: 42-46									
5-0	72 h	15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work done during n	most of working	16b. Kind of Business/li							
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		23a. Part1. Entar tha disaasa, or complication that caused the death. Do not entar the mode of dying, such shock, or haart failure. List only one cause on each line.	h as cardiac or respiratory a	rrest,	Approximata tntarval Batween Onset and Death						
	Physician /Medical	Immediata Causa (Final	200		5,150, 2,12, 5,02,17						
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Division	tal or Attending P rs after death. al Director: After t led in by the funers Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28a. Place of Injury - At home, tarm, street, factory, office building, atc. (Specify)		Street and Number or Ru wn, Stata)	ral Route Number,						
	Hospi 4 hou Funer tely fill	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and manner stated. 29 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.									
	within 2 To the comple	29b. Signatura end title of certifiar 29c. License numb		29d. Data signed (Month	(Day, Year)						
		1 Steph 155 03	8687	3/16/	99						
	12+	30. Name and address of person who completed cause of death them 23a) (Type, Print) VATZ, M.D.	139 OLO SOLO	mons An	reproces, mg						
	State Registrar	31. Data filed (Month, Day, Year) Se Registrar's Signature									



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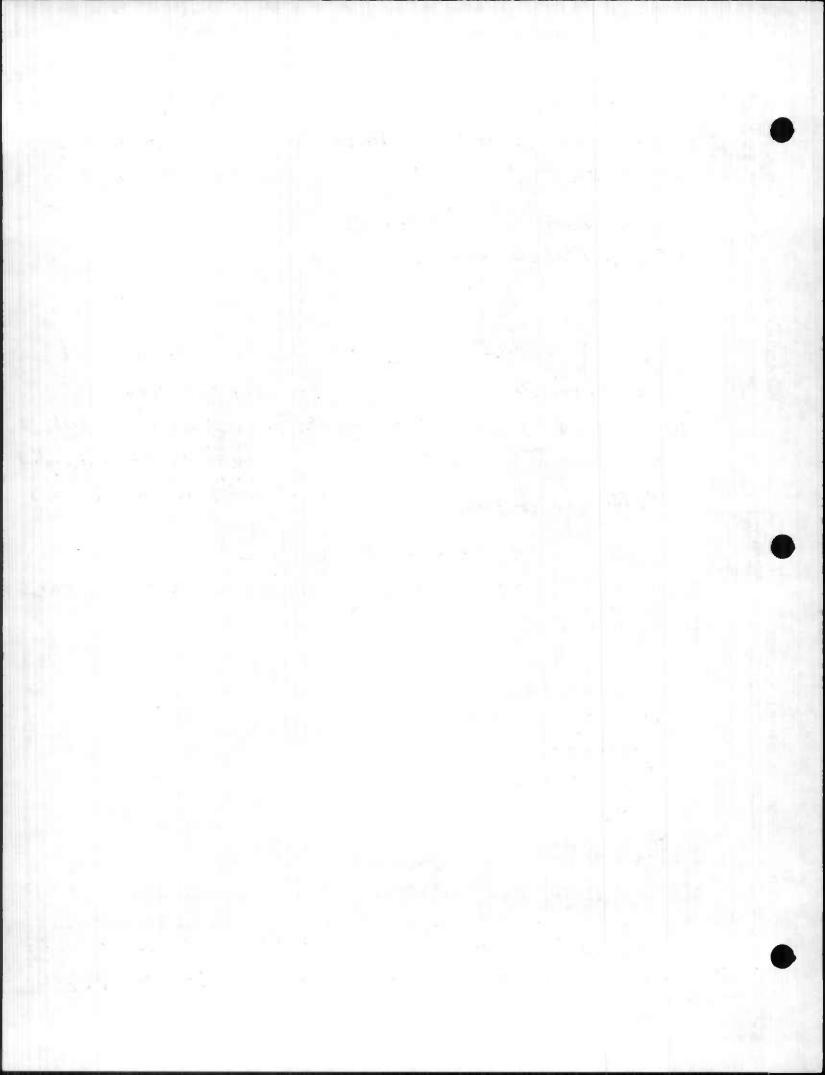
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month **Physician** , 45AM Do 03 999 4a Facility Neme (If not institution, give street end number) /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner ong Green Center Gensis Eldercare Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthpleca (State or Foreign Country) 6. Sex 8. Dete of Birth /Month, Dey, **Funeral** 10 M 20 F Deys 228-1/8-2835 Usuel Residence of Decedent 62 Yrs. **Director** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow 7 is marked other than "natural", or Nems 23s or 28s-f shor traumatic event, the Modical Examines must be numbed as 1 Tes 2 No Director 10s. Stylest and Number more 10f. Zip Code 10g. Citizen of Whet Country? Eas S 2/2/2 Hvenye Funeral rase death 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Peges 1 and 2 should be filled within 72 hours after Department of Health and Mental Hyglena. Important: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Black PV 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) Supervisor ustodial 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be lillram rances Spradle Goode 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relettonship (Type, Print) 20b. Pleca of Disposition (Name of cemetery, cremetory or other place) March Date Dewarg 20a. Method of Disposition any injury or o 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Himore 4 ☐ Donetion 5 ☐ Other (Specify) LION 22. Name and Address of Facility Douglass 21. Signature of Funeral Servica Licen Funera Service 1701 McCulloh Street, Baltimore, MD. 21217 ent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, hock, or heart failure. List only one cause on each line. Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner cardiovascular attending physician and for use es the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Box 68760. Due to (or es e consequence of): 98 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. the i 1 Yes 2X No signed by 3 Probably 4 Unknown Division of Vital Records, PV 24b. Were autopsy findings evelleble prior to completion of cause of deeth? 24e. Was en eutopsy performed? Completed peen certificata has percholesterolem'a 2000 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical exemiter? Be 26. Plece of Deeth (Check only one) 1□ Yes No Hospitef: 10 Other: Sursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth

1 Valuaturel

2 Accident 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 ☐ Yes 2 No 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the ceuse(s) end menner es steted.

Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) end manner stated. 29a. Certifier edicai (Check only one) 29b. Signatury and title of cert 29d. Date signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Levenson MD 515 Fairmount 31. Dete filed (Month, Dey, Yeer) 32. Registrer's Signature State MAR 1 9 1999



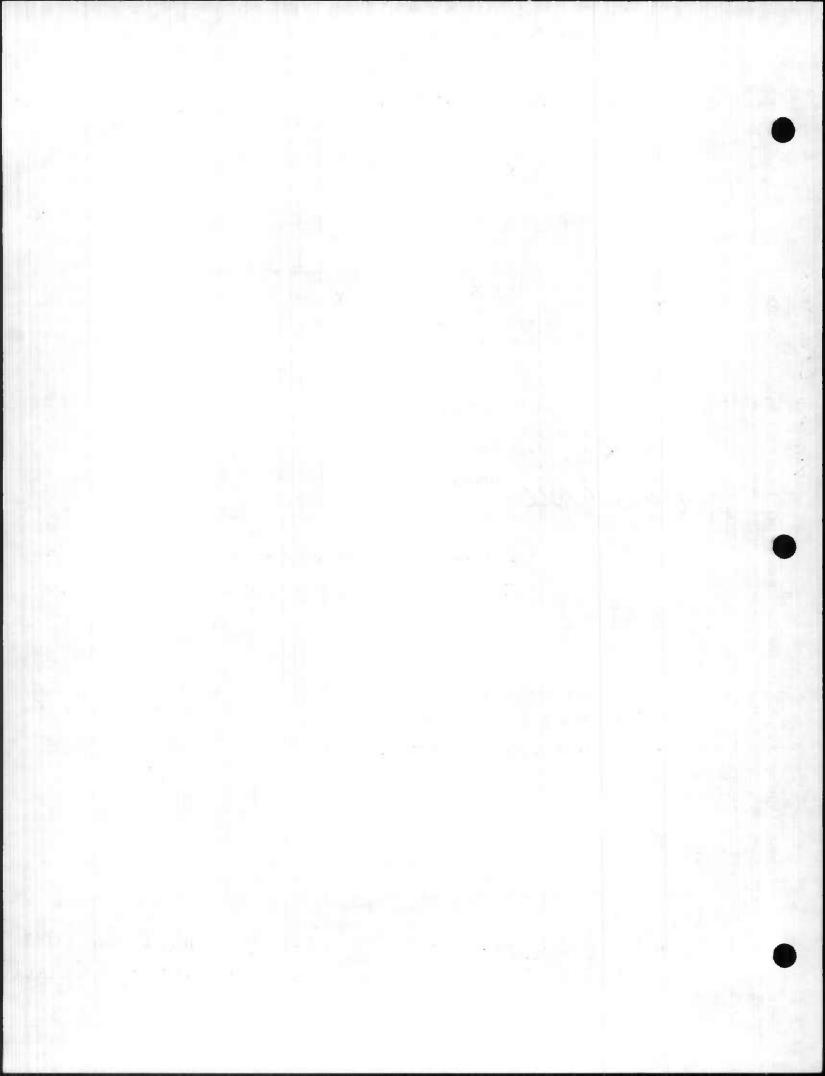
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32. Ragistrer's Signature

DHMH 16 Rev 6/95

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Dorothy M. Dugge March 17,1999 2040 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth St. Agnes Healthcare Baltimore If Under 24 Hrs. 8. Date of Birth
(Month, Dey, Yaar) If Undar 1 Yaar 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 □ M 2 🗓 F Months Yrs. 83 143-01-1175 Jan 29, 1916 Maryland Usual Residence of Decedent 10a State 10b Counts 10c. City, Town or Location 10d. fnside City Limits 1 No Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1820 Spence Street, Apt. 106 21230 USA 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. Black, Whita, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Datas: 1 Never Marriad 2 Married 1☐ Yes 2☑ No Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 6 Homemaker Own Home 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Walter Hardy Mary Bosley 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Joann Downs / Daughter 112 Summer Hill Park, Crownsville, Maryland 21032 20b. Place of Disposition (Name of cematery, cremetory or other place) 20c. Location - City or Town, Steta 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donetion 5 Other (Specify) Loudon Park Cemetery 3/22/99 Baltimore, Maryland 22. Name and Address of Facility 21. Signat r Fun-rai Sarvice Licensas Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 -23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) IN JUNY 5 days Lung Xears 2 Breast CANCEL Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings availeble prior to 24a. Wes an autopsy performed? completion of cause of deeth? 2 0 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 Inpatient 2 ER/Outpatient 3 DOA 28c. fnjury et Work? 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 5 Pending investigation 1 Yes 2 No

Physician /Medical Examiner

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physician

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after death Director:

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Certification:

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with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Madical Examiner must be notified at once.

altimore, Maryland 21215-0020

Examiner Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated avants resulting in death) Last Physician/Medical # 8 1280

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Manner of Deeth

> 1 Natural 2 Accident 6 Could not be determined 3 Suicide 4 ☐ Homleide

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

MAR 1 9 1999

28e. Place of Injury - At homa, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end pleca, and dua to the cause(s) and manner stated. 29b. Signature and title of certifier

29a. Certifier

(Check only one)

29c. License number

29d. Date signed (Month, Day, Year) March 17, 1499

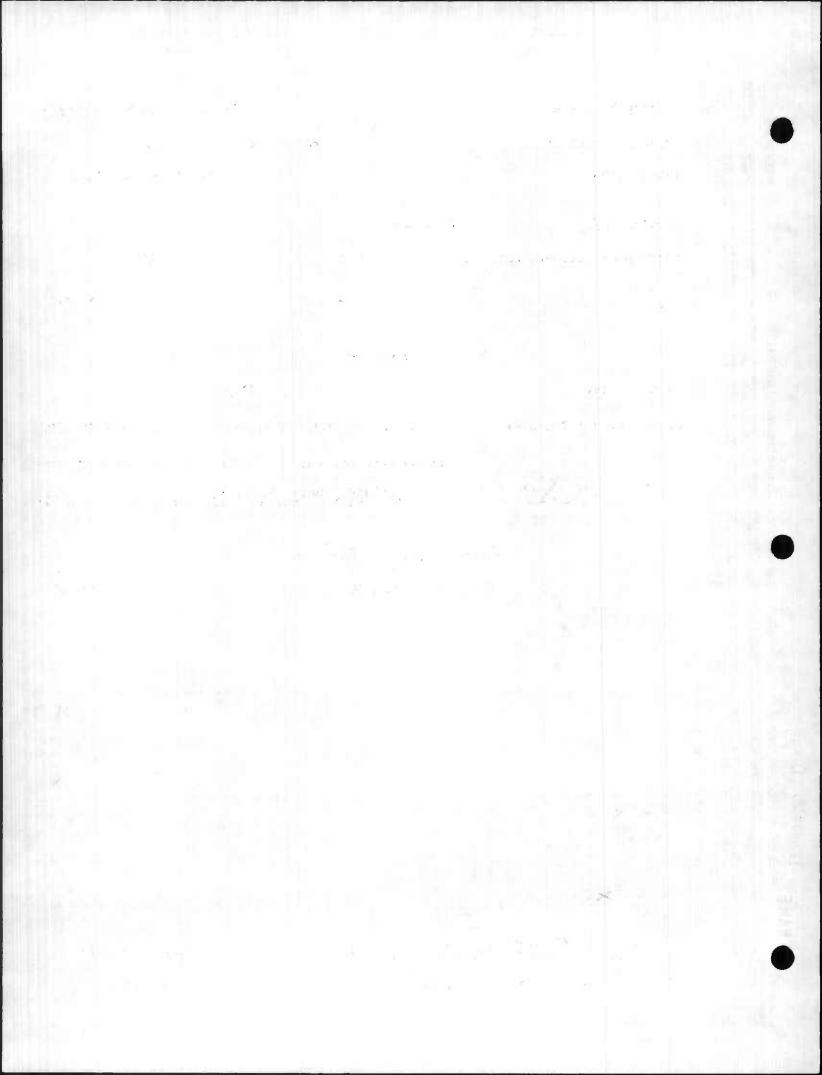
House officer 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Feinstein 900 Caton Daniel MO AVENUE 31. Date filed (Month, Day, Year)

Bultimore, Maryland

Registrar

22. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

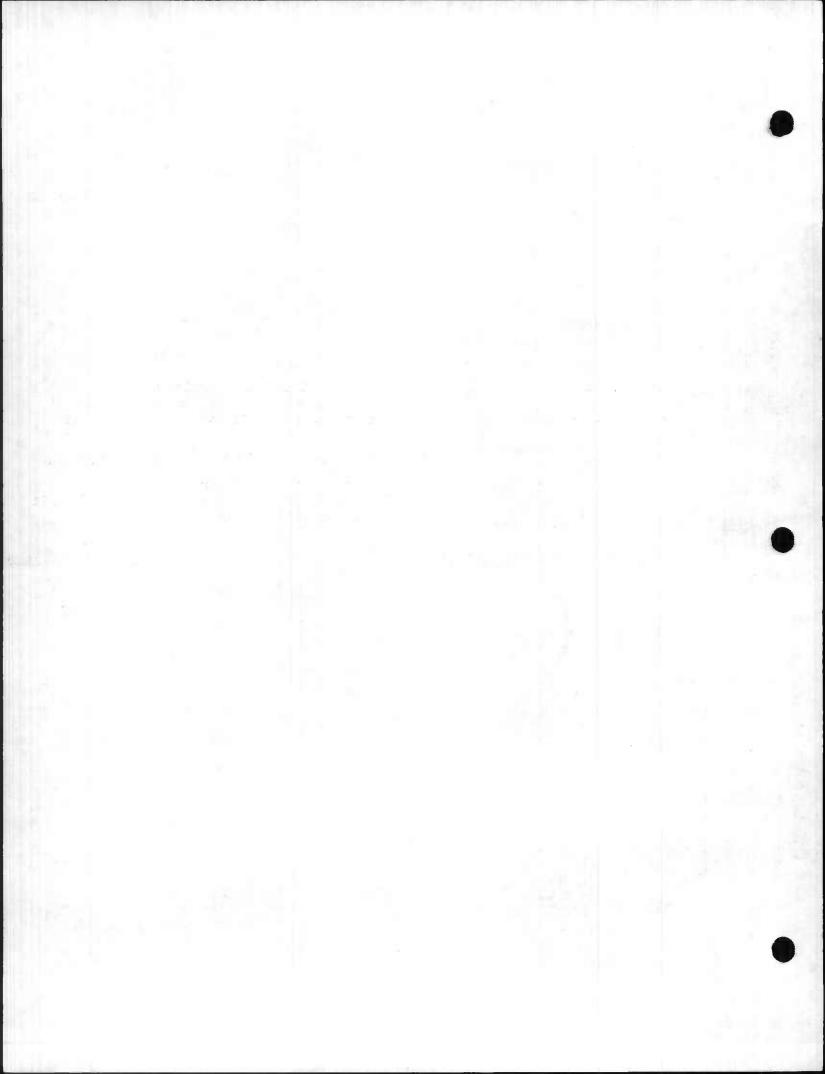
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Michael Eugene 7.30pm Damico March 1999 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital N/A Baltimore If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1∆ M 2□ F **Funeral** Months Days Hours Yrs. 212-05-9208 91 Director Jan. 23, 1908 Washington, D.C Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nas 2 No Directo Maryland N/A r than "natural", or items 23s or 28s-f the Medical Examiner must be notifie Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3942 Hickory Avenue U.S.A. 21211 Funeral 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yas 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 ahould be lited w Department of Health and Mental Hyglen Important: if them 27 is marked other thy any injury or other traumatic event, the GDSs. 6 Welder Construction 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Felix Damico Philipino Perticone 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline N. Damico (wife) 3942 Hickory Avenue, Baltimore, Maryland 21211 altimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Buriat 2 ☐ Cremetion 3 ☐ Removel from State Woodlawn Cemetery 3/20/99 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility A. Alan Seitz, Jr. Funeral Home 21. Signature of Funeral Service Licensee llan 3818 Roland Avenue, Baltimore, Maryland 21211 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician Heart Failure /Medical tmmediate Cause (Final disease or condition resulting in death) 2 weeks Examiner Due to (or as a consequence of): 2 weeks Preunoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): the attanding physician hed for use as the buns edical Due to (or es e consequence of): Physician/M Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown ģ neurodegenerative disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate 1 Yes 2 No 1 ☐ Yas 2 ☒ No 25. Was case referred to medical examiner? 89 26. Place of Deeth (Check only one) Hospital: 1 Inpetient 2 □ ER/Outpatient 3 □ DOA To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 튑 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? 1 Naturat 5 Pending investigation 1 Yes 2 No 2 Accident after deal! Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) within 2 To the i 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AT 2438946 Dares waln MD March 17, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNION SRIKANTIAH MEMORIAL HOSPITAL. SARASWATI 31. Date filed (Month, Day, Year) 82. Registrar's Signeture State Registrar

DHMH 16 Rev 6/95

Damico



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death VONALDSON Month Day PATRICIA 12.19 (N MARCH 1999 16 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street end number) HOSPITAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Markha Days Hours Min. (Month, Dey, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Months 1 M 2 F Days 220-38-7628 March 3, 1943 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 ☑ No Md. Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 110 Tenth Avenue U.S.A. 14. Race - American Indian, 21225 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Maritei Status Biack, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th 0 NSA Federal Government 18. Mother's Name (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Last) William H. Donaldson Dorothy E. Hammer 19a. Informant's Neme/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 110 Tenth Avenue Baltimore, Maryland 21225 Date 20c. Location - City or Town, Stete 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Memorial Park 3/19/99 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Avenue Baltimore, Maryland 21225 shock, or heart failure. List only one cause on each line. immediate Cause (Final OBSTRUCTIVE AND RESTRICTIVE LUNG DISGNE 12 YEAR disease or condition resulting in death) Due to (or as a consequence of): KYPHOSCOLIOSIS Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Onknown 24a. Was an autopsy performed?

Physician /Medical Examine

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To the Hosp within 24 hor To the Fune completely fi

The law requires that the death certificate be executed

Attending Physicien:

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

by

Completed

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Certification:

Medical

Physician

/Medical

Examiner

10a. State

Funeral

Director

x 28a-f show

parmit. Pages 1 and 2 should be filled within 72 hours after death with 1 Department of Haalth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 2 any injury or other treumatic event, the Mexical Expansion must be sent.

Baltimore, Maryland 21215-0020

Directo

Funeral

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the Merylend

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

24b. Were eutopsy findings available prior to completion of ceuse of death? 1 Yes & No 1 Yes 2 No

25. Was cese referre examiner?	d to medicai
27. Manner of Death	
1 ☐Natural 2 ☐ Accident	5 Pending investigation

3 Suicide

4 ☐ Homicide

1 Inpetient 2 □ ER/Outpatient 3 □ DOA 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

Wilcante

29c. License number 13132

29d. Date signed (Month, Dey, Year) MARCH 16 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 SOUTH HANOVER STREET SRIKANPH RAMACHANDRUNI

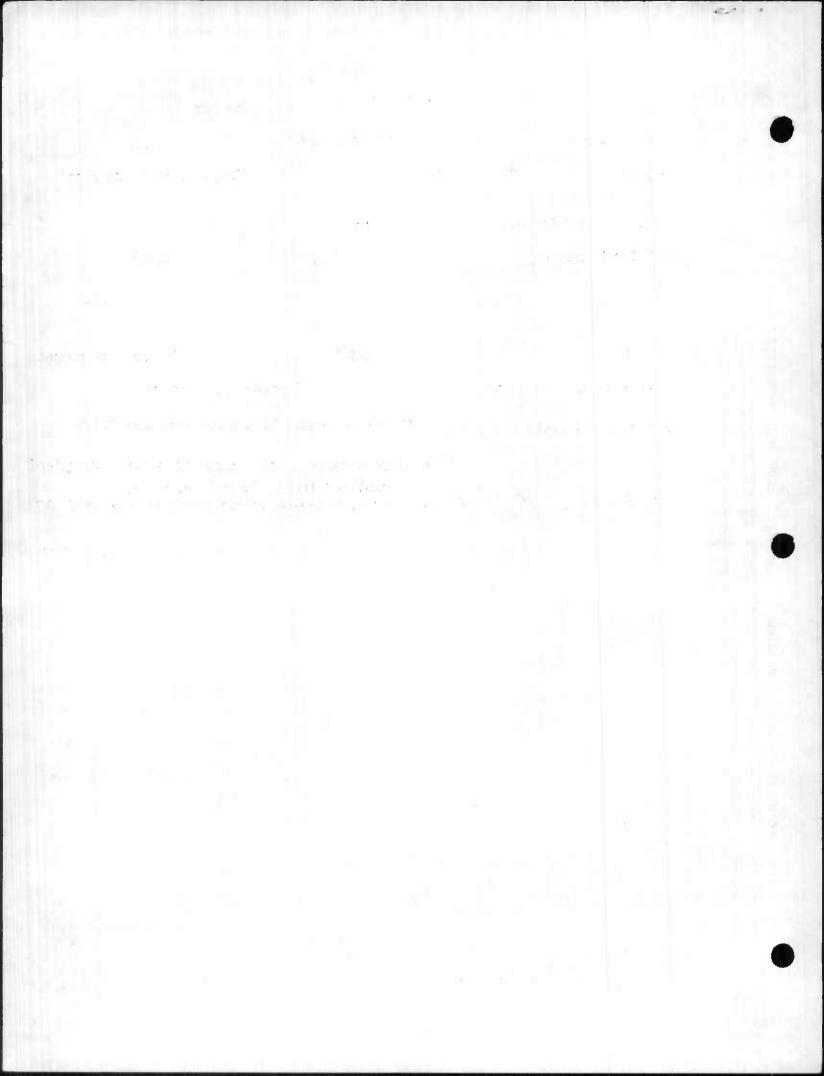
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BALTIMORE MO

State Registrar 31. Date filed (Month, Day, Yeer) MAR 1 9 1999



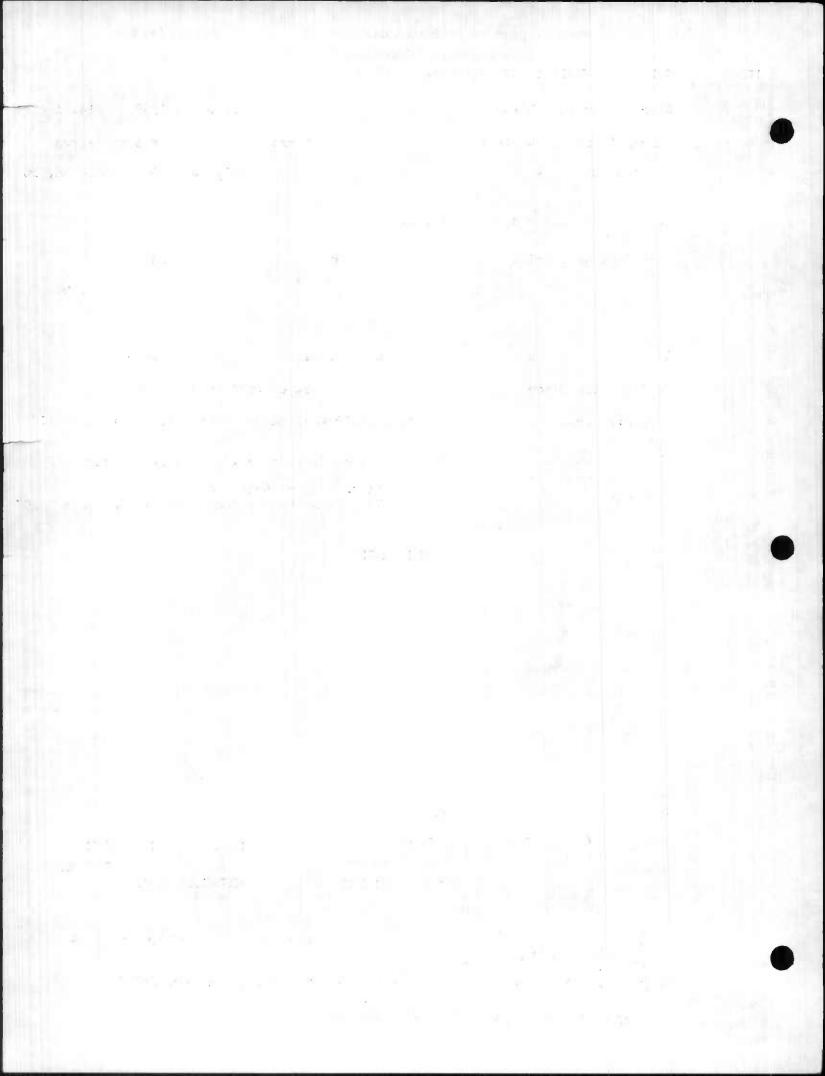
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S. Social Security Number 6. Sax 12 M 2 F 7. Aga (In yrs. last birmday) 10 Min. 10 M	y of Death Ince George 9. Birthplace (State or Foreign Country) Washington, D(10d. Insida City Limits 1 Yas 2 No. What Country? ce- Amarican Indian, lock, Whita, atc. American fy: Indian Businass/Industry se ma) s. Stata, Zip Coda) Maryland 21771 - City or Town, Stata Spring, MD
Richard Arnold Dixon Aarch 14, 1996	14:21 p.n. y of Death Ince George 9. Birthplace (State or Foreign Country) Washington, D(10d. Insida City Limits 1 2 Yas 2 New What Country? Cee - Amarican Indian, tok, Whita, atc. American fy: Indian Businass/Industry See ma) 3. Stata, Zip Coda) Maryland 21771 - City or Town, Stata Spring, MD
Second Security Number 6. Sax 7. Aga (in yre. last birthday) 10. City, Town or Location of Death 4c. County 10. Social Security Number 6. Sax 7. Aga (in yre. last birthday) 10. Months 20	y of Death Ince George 9. Birthplace (State or Foreign Country) Washington, DC 10d. Insida City Limits 1 1 2 2 No. What Country? Coe - Amarican Indian, and the country in the country. Indian Businass/Industry See ma) 5. Atata, Zip Coda) Maryland 21771 - City or Town, Stata Spring, MD
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Symbol S	Washington, DO 10d. Insida City Limit: 1
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3430 Stonehall Drive 20705 USA	ce - Amarican Indian, lok, Whita, atc. American fy: Indian Businass/Industry See ma) Son, Stata, Zip Coda) Maryland 21771 - City or Town, Stata C. Spring, MD
3430 Stonehall Drive 20705 USA	ce - Amarican Indian, lok, Whita, atc. American fy: Indian Businass/Industry See ma) Son, Stata, Zip Coda) Maryland 21771 - City or Town, Stata C. Spring, MD
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William Able Dixon 19a. Intermant's Nama/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town Mark Dixon/Son 1605 Shaffersville Road, Mt. Airy,	se ma) s n, Stata, Zip Coda) Maryland 21771 - City or Town, Stata - Spring, MD
William Able Dixon 19a. Informant's Nama/Relationship (Type, Print) Mark Dixon/Son 20a. Mathod of Disposition 19a. Burial 2 Cramation 3 Ramovel from Stata 4 Donation 5 Othar (Specify) 21 Signature Funeral Service Licenses 22 Nama and Addrass of Facility 23a. Part. Enter the disease or computer of the death. Do not enter that mode of dying, such as cerdiac or respiratory arrast, 23a. Part. Enter the disease or computer of the death. Do not enter that mode of dying, such as cerdiac or respiratory arrast, 23b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town 1605 Shaffersville Road, Mt. Airy, 24c. Deate of Disposition (Nama of cematary, cramatory or other place) 25c. Nama and Addrass of Facility 25c. Nama and A	ma) S. S. Maryland 2177 City or Town, Stata Spring, MD
William Able Dixon 19a. Informant's Nama/Relationship (Type, Print) Mark Dixon/Son 10a. Mathod of Disposition 10b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town 1605 Shaffersville Road, Mt. Airy, 10b. Place of Disposition (Nama of cematary, cramatory or other place) 10c. Place of Heaven Cemetery 3/17/99 Silver 10c. Nama and Addrass of Facility 10c. Place Runeral Home, Inc. 10c. Place Runeral Home,	ma) S. S. Maryland 2177 City or Town, Stata Spring, MD
William Able Dixon 19a. Informant's Nama/Relationship (Type, Print) Mark Dixon/Son 10b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town 1605 Shaffersville Road, Mt. Airy, 1605 Shaffersville Road, Mt. A	Maryland 21771 City or Town, Stata Spring, MD
19a. Informant's Nama/Relationship (Type, Print) Mark Dixon/Son 1605 Shaffersville Road, Mt. Airy, 20a. Mathod of Disposition Burial 2 Cramation 3 Ramovel from State 4 Donation 5 Other (Specify) Signature Funeral Service and Number or Rural Routa Number, City or Town 120b. Place of Disposition (Nama of cematary, cramatory or other place) Gate of Heaven Cemetery 3/17/99 Silver 22. Nama and Addrass of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, shock, or heart failura. List only or should be added the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, Immediate Ceusa (Final disease or condition rasulting in deeth) Due to (or es e consequence of): Due to (or es a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Maryland 21771 -City or Town, Stata - Spring, MD
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Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, 23a. Part1. Enter the disease or composition of the property of the p	Maryland 2070
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use of 1 Yes 2 No.	ontribute to the cause of deat
1 □ Yes 2 □ No	3 □ Probably 4 Vunkno
24a. Was an autopsy performed?	24b. Wara autopsy findings evailabla prior to complation of ceusa of death?
1 Vas 2□No	1 ☐ Yes 2 ☐ No
25. Was cese referred to medicel 28. Plece of Deeth (Check only one)	
25. Was cese referred to medicel axaminar? Hospital: 1 Inpatiant XXER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidance 8 Other:	ther (Specify)
28b. Tima of 28c. Injury et 28d. Dascribe how injury occur	ırred
1 Naturel 5 Pending invastigation 2 Accident Pound: Naturel 1 Naturel 2 Accident 2 Accident 3-13-1999 11:00 INHALED SMOKE IN	HOUSE FIRE
3 ☐ Suicida 4 ☐ Homicide 3 ☐ Suicida 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined building, etc. (Specify) 5 ☐ City or Town, Stata) 3 ☐ City or Town, Stata) 3 ☐ City or Town, Stata)	Ber of Bural Boule Number,
FOUND: RESIDENCE BELTSVILLE, MARYL	
29a. Certifiar (Check only one) 1 Certifying Physician: To tha best of my knowledga, daath occurred at tha time, date and place, and dua to tha causa(s) and my opinion, daath occurred at tha tima, date and place and mannar stated.	nannar as stated. , and dua fo tha ceuse(s)
29b. Signatura and fitta of certifiar 29d. Data sign	and (Month Day Vers)
Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 212	16, 1999
ate ate at MAR 1 8 1999 32, Ragistrar's Signeture B. Apachs	16, 1999

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Q Q

					Cei	rtificat	e of	Death		Reg.	No.		
Physic	ian	Decedent's Name (First, Middle, Last) Dete of Daeth Month Day								Day	Yeer	3. Time of Death	
/Medi		ELSIE MARIE	DEMBECK	BECK					Marc		12 1999 7:45		7:45 am
Exami		4e. Fecility Nama (If not institution, g	give street end nu	mber)				4b. City, Town, o	Death 4c. County of Deeth				
		STELLA MARIS						TOW	SON		BAL	TIMOF	RE
Funeral		5. Social Sacurity Number 6	. Sex	7. Age (In yrs	last birthday)	If Undar		If Undar 24 H	rs. 8. Dete	of Birth	arl	9. Birthpla	e (Stete or Foreign
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D		Usual Residence of Decedant											
arylan		10a. Stete 10b. County		10c. C	ity, Town or Lo	ecation						100	I. Inside City Limits
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hours after deeth with the Maryland ural*, or fleme 23a or 28a-f ahow at Exam ret must be notified at at by Funeral Director	re	10e. Street and Number				10f. Zip	Code			10g.	Citizen of V	What Country	n
	O E	119 FAIRMON	r DRIVE			2	2101	Δ			U.S.	Δ.	
	era	11. Marital Status	12. Was Dec	edant Evar in U	J,S. 13. 1			Hispanic Origin? an, Mexican, Pu	(Specify Yes			e - Amarican	Indian,
	E	1 Nevar Married 2 Married	Armed Fo		1	f Yes, spe	city Cubi	an, Mexican, Pu	erto Rican, et	c.)	Bled	ck, White, etc	D.
	by	3 Midowed 4 Divorced	If Yes, Gr	/6"		1 🗆 Yes	2/5 No	Specify:			Specify	WHI	TE
fora	귷	15. Decedent's			16a. Dece	dont's Heur	al Occur	nation		166	Kind of Ru	usiness/Indu	
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Ked of	Be			SKI					ther's Name (First, Middle, Meiden Sumeme)			10)	
marked matic e	2	JOHN SEGLI	NSKI					STELLA ROSZY					
2 8 8 8		19e. Informent's Name/Relationship	(Type, Print)					end Number or					
		MRS. MARLENE I	BOROWSK	Ι	7 LE	EXINC	GTON	I RD. E	BEL AI	CR, M	IARYL	AND 2	21014
		20a. Method of Disposition		20b.	Place of Dispo cemetery, crer	sition (Name	me of	ca)	Dete	20c	Location -	City or Town	n, State
		1 Burial 2 □ Cremation 3 4 □ Donetion 5 □ Other (Spec		State				CEME.3	1/16/9	9 BA	т.ттм	ORE,	MD.
permit. Page Departmant of Important: If any injury or once.		21. Signature of Funerel Servica Lic											
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		Charles ?	Jacmo	ween				DALK AV				MD.	21222
		23a. Part1. Enter the disease, or co shock, or heert feilure. List on	mplications that of	aused the dea	th. Do not ent	er the mod	te of dylr	ng, such as card	iac or respire	tory errest,		A	pproximete ntervel Between
ysician												C	Inset and Death
Medical		Immediete Causa (Final	7 D	PROTOSC	T.F.DOTT	CAP	מסדת	ZA SCIIT. A D	DISTA	CF			
caminer		disease or condition resulting in deeth) e. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of):											
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physician end s the buriel-transit	Examiner		b	b									
el-tra	Xa	Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury		Due to (or es e conseq	quence of):							
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the the	Medical	that initiated events resulting in deeth) Last		Dua to (or as a conseq	uance of):							
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ate has b			Hospital:	26. Place of Dee						-4			
ate has b page 2 si	Be	25. Was case referred to medical examiner?		npatient 2	ER/Outpetien			440 Nursing	Homa 5□				
ate has b	To Be	examiner? 1 ☐ Yes 2 ☑ No	10										
er this certificate has neral director, page 2	To Be	examiner? 1 Yes 22 No 27. Manner of Death	10	of Injury th, Dey Yeer)	28b. Time of Injury		28c. Injur Wor		28d. Des	cribe how in	njury occur	red	
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D 15504

Timonium, Md 21093

2300 Dulaney Valley Rd

3-12-99.

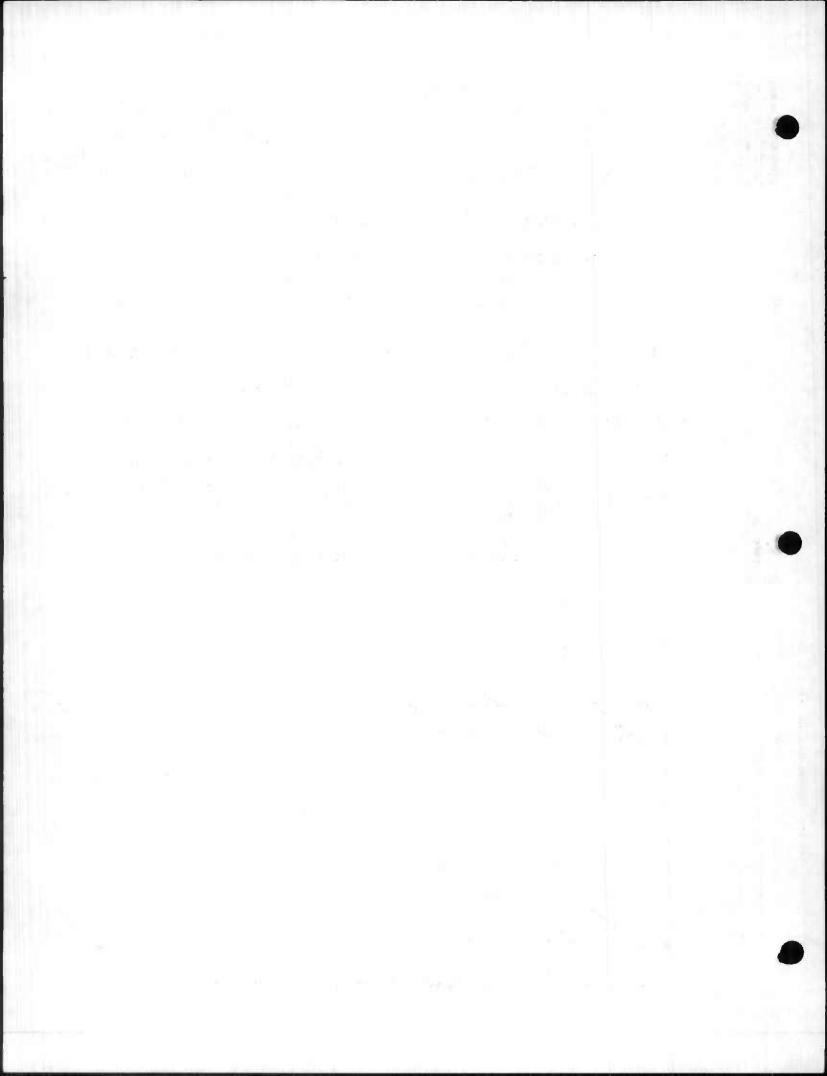
State Registrar

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

Eddie Nakhuda, M.D.

31. Dete filed (Month, Dey, Year)

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** 999 JOSEPH ERIC DEVAUGHA MARCH 16, /Medical 4a Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIHORE
If Under 24 Hrs. 8. Date of B RITCHIE HOSPICE 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Months 2 46 Yrs. Hours 12M 20 F 215-60-6218 Director 1AY05, 1952 Usual Rasidence of Decedent 10e. Stata 10b County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Directo MARVLAND 10g. Cirizen of What Country? 10e. Street and Number DRIVE USA, 14. Race - American Indian, SHANNON flams 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Navar Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: b 1 Yes 2 No Specify: à BLAC 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CEMENT FINISHER (SUPERVISOR) CONSTRUCTION CO +HGRADE 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be EVAUGHN EDWARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is 9 CARROLL STREET BALTIMORE MD. 2/230 sposition (Name of Data 20c. Location - City or Town, State ARMENTRAL DEVAUGHN altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1. Burial 2 Cremation 3 Removal from State 21. Signature of Funeral Service Licensee

22. Nama and Address of Facility

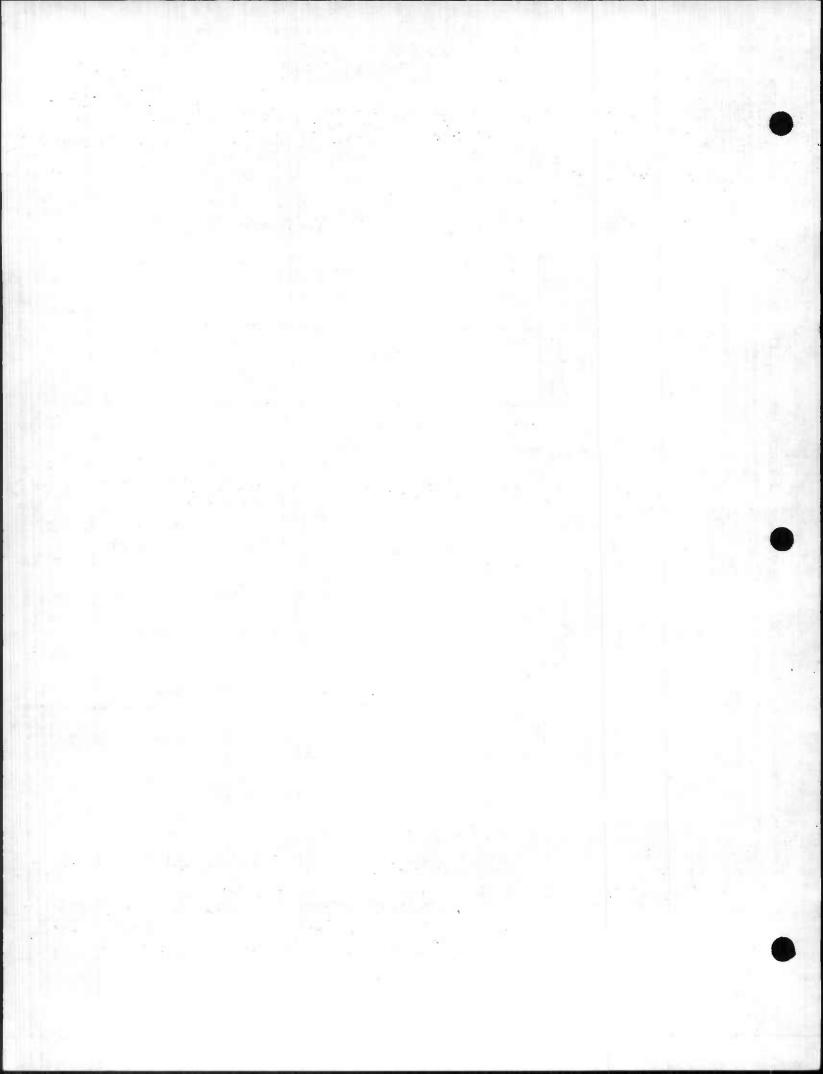
22. Nama and Address of Facility

23. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory artast,

Approximate 5 Othar (Specify) CEMETERY 03-22-99 LANSDOWNE, M.D. **Physician** /Medical Immediate Cause (Final Deficary Diseasedisaasa or condition resulting in death) Examiner and Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760 Physician/Medical the Dua to (or as a consequence of) P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yaa 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 2 19 No 1 Yes 1 Yas 2 No certificate Division of Vital l or Attending Physician: after death. Director: After this certific 25. Was case referred to medical examiner? 89 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Dother (Specify) 405 106 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? 5 Panding investigation 1 Natural 1 Yes 2 No 2 Accidant 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide To the Hospital co. within 24 hours after To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signatura and time of certifier 29c. License number 29d. Date signed (Month, Day, Year) win 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 828 M. Entawst - Balto. Md 21201 Robert C LYWIN D N. 31. Data filed (Month, Day, Year) 32. Registrar's Signature MAR 1 9 1999 Registrar

DHMH 16 Rev 6/95

Daugh



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 3 2

		Decedent's Name (First, Middle, L.			ertificate of	_ ~~	2. Date of Deat	eg. No.		Time of Death
Physici /Media	_	RICHARD	STACK FORI)			Month	Day 8	1999 C	7:10AM
Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Count							of Death ALTIMO	RE
Funeral Director			Sex 7. Age (In yn	77 Yrs.	Months Days		8. Date of Birth (Month, Day, MAY 23	Year) , 1921	9. Birthplace Country) MAR	(State or Foreign
Manyland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD HOW		city, Town or L		COTT CITY				nside City Limits
th with the 23e or 28e	al Director	10e. Street and Number 3004 NORTH RID	GE ROAD #229		10f. Zip Code	21043	1	0g. Citizan of V	Vhet Country?	
72 hours after death with the Maryland "natural", or items 23e or 28e-f show vitical Examiner issues be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☐ No if Yes, Give Year or Dates:	U,S. 13.	Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 X No	Hispanlc Origin? (Spe an, Mexican, Puerto l Specify:	ecify Yes or No- Rican, etc.)	Biac	e - American Ir k, White, etc.	ndian,
72 ho	Completed	15. Decedent's E (Specify only highest gi	ducation ade co <i>mpleted)</i>	16a. Deci	edent's Usual Occu	pation during most of working)	ng	16b. Kind of Bu	siness/Industr	у
withir Bne. than	ошр	Eiementary/Secondary (0-12)	Collega (1-4or 5+)		iffe. DO NOT use retired) CLASSIFIED ANALYST				NSA	
be filed htal Hyg d other	To Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname) BERTHA (STACK)				
nd 2 she lith end 27 ls m r traum	-	19a. Informant's Name/Relationship AMPARO NAN FORD	(Type, Print) (WIFE)			t and Number or Rura ERD #229		City or Town,		_(e) 21043
Pages 1 en nent of Heal int: If item 2 iry or other		20a. Method of Disposition 1 ☐ Burlal 2 【Cremation 3 (4 ☐ Donation 5 ☐ Other (Spec	Removal from State	cametery, cre	osition (Name of ematory or other plate) ASH. CREM		Date /19/99	20c. Location -		State
permit. Pages 1 Department of H Important: If ite any injury or ott		21. Signaling of Funeral Service (G	- (X)		22. Name and Addr		TZKE FU		OMES,	INC. 228
		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the de y one cause on each line.	ath. Do not e	nter the mode of dy	ing, such as cardiac o	or respiratory arr	est,	App	proximate erval Between
Physician /Medical Examiner		Immediate Causa (Final disease or condition resulting in death)	a. Severe Ch	ONIC (or as a conse	Obstruction	c Pulmona	ary Di	sease	1	Years Years
D :=	iner	<u> </u>	Cardiac	-1	leytheria					Years
ificate be executed g physician and as the bunal-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conse	equenca of):				i	
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the death cer y the ettendin ached for use	by Physician/N	Part II. Other significant conditions	contributing to death but not re	suiting in the	undarlying causa gi	iven in Part I.	23b. Did to	bacco use co	ntributa to the	cause of death?
es thet the death certific igned by the ettending p be deteched for use as		CVA, &	neumonia,	Urina	ry truct	Infection	10Y	es 2 No	3 Probabl	y 4 Tonknown
aw requires been s	Completed	Hypothyroidia	m, PEG	tube	feeding)——	24a. Was a perior		avallab	autopsy findings ble prior to etion of cause h?
The la	Con						1 🗆 Y	es 212No	1 □ Ye	s 2 No
Physician: The rthis certificate ral director, pag	Be C	25. Was case rafarred to medical examiner?	Hospital:		_ 0	26. Place of Death				
S 00 D	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c. Inju	4 Le Nursing Ho	me 5 ☐ Reside 28d. Describe h			
To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral.	Certification:	3 Sulcide 6 Could not detarmined		homa, farm, s	traat, factory, offica		28f. Location (S City or Town		er or Rural Ro	ute Number,
n 24 hours n 24 hours ne Funera	edical (29a. Cartiflar (Check only one)	hysician: To the best of my ki miner: On the basis of examination and manner stated.	nowladga, daa nation and/or i	th occurred at tha t nvastigation, in my	ima, data and piaca, a opinion, daath occurr	and dua to tha c ad at tha tima, d	ausa(s) and ma lata and place,	innar as stated and dua to tha	t. causa(s)
To the To the Comp	M	29b. Signature and title of certifier	010			se number		9d. Date signe		
		1 Blying	Xeo 4		L	52544		MAR	18,10	199
5 per		30. Name and address of person who Benjamin S. L.	completed cause of death (Ite	om 23a) (Type			tousville	mD	2122	8
	ite	31. Date filed (Month, Day, Year)	32/Registrar's Sig	nature	0	,		-		

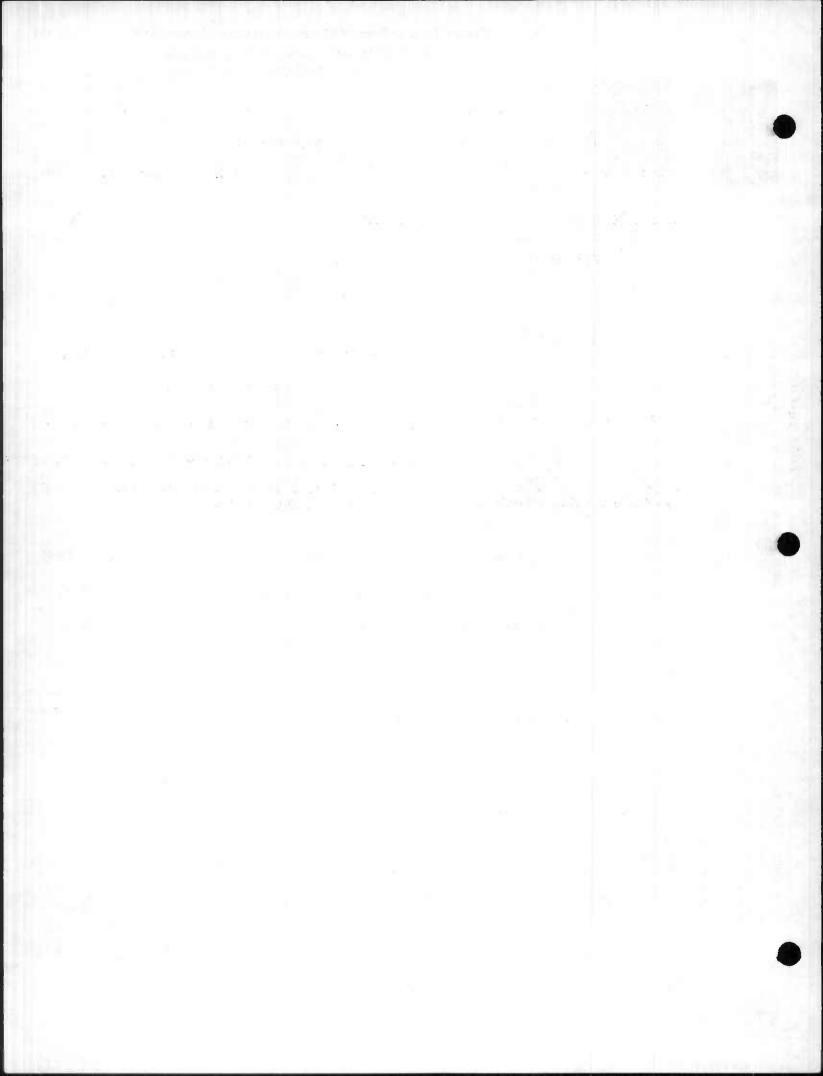
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death Month MARCH 1. Decedant's Nama (First, Middla, Last) FRANCES FINCH 17 1999 4c. County of Death 4e. Facility Nema (If not institution, give street and number) Maryland Greneral Hospital 4b. City, Town, or Location of Death Partimore City N/A

Physician

/Medical

Examiner

	Funeral Director		5. Social Security Number 6. S 226-14-5051		(In yrs. last b	virthday) If Undar 1 Ye Months De		rs. 8. Date of Bir	rth ay, Year) L 1909	9. Birthplaca (Stata or Foreign Country) NORTH CAROLI
	_		Usual Rasidanca of Dacadant		70			UAN	LIJUJ	NORTH CAROLL
	/lend		10a. Stata 10b. County		10c. City, To	wn or Location				10d. Insida City Limits
	h the Merylend r 28a-f ahow	to	MARYLAND N/A		BAI	TIMORE CI	TY			XXYes 2□ No
	r 284	Director	10e. Street and Number			10f. Zip Code	0		10g. Citizen of V	What Country?
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50	72 hours effer death with the Merylend natural, or items 23a or 28a-f show pical Examiner must be notified at	/ Funeral	11. Maritel Stetus 1 ☐ Navar Married 2 ☐ Married	12. Wes Decedant E Armed Forcas? 1 ☐ Yas 2 🗓 No If Yas, Giva	var in U,S.	13. Was Decedant of If Yes, specify C	of Hispenic Origin? uban, Maxican, Pue	(Specify Yes or No erto Rican, atc.)	o- 14. Rac Blac	e - American Indien, ok, Whita, atc.
00	72 hours natural',	d by	3 XWidowad 4 ☐ Divorced	Year or Detes:			opouny.		Specify	BLACK
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altimore			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐	Removel from State	20b. Plece camate	of Disposition (Name of ary, cramatory or othar p	olaca)	Data	20c. Location -	City or Town, Steta
E	Pages ment of ant: If its ury or o		4 □ Donation 5 □ Othar (Specific		KIN	NG MEMORIA	AL PARK	3-22-9	99 BALT	IMORE, MARYL
Balt	permit. Page Department of important: If any injury or once.		21. Signature of Funeral Service Light	blann			IAM C BR			RAL HOME PA
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	Physician /Medical Examiner	ler				potensio consequence of): 9 CK Syr consequence of):				minutes
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ó	death certificete be execui e ettending physician end ind for use es the buriel-trar	Ä	Sequentially list conditions, if any, leading to immediate cause. Entar Undarlying Ceusa (Disaasa or Injury that Initiated avents	GARAGE	20115	BoiNe	15.			Dair
68760,	ote be	Ica	that initiated avents resulting in death) Last	c. Crock of the	ue to (or es e	consequence of):		-		Days
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	The law ate has b page 2 s	mo;						1 🗆	Yas 20 No	1 ☐ Yes 2 ☐ No
Vital		Be C	25. Was casa rafarrad to medical				26. Placa of D	eath (Check only	ona)	
>	5 00	70	axaminar? 1 ☐ Yas 2 ☑ No	Hospital:	t 2 ER/C	outpatient 3 DOA	Othar: 4 Nursing	Homa 5 ☐ Rasi	dance 6 Oth	ar (Specify)
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	To the Hospital or # within 24 hours effer To the Funeral Director Completely filled in b	edical (29a. Certifiar (Check only one)	ysician: To the best of hiner: On the basis of e and mannar state	examinetion a	ia, death occurred at tha nd/or invastigation, in m	tima, dete and placy y opinion, daath oo	ce, and dua to tha curred at tha tima,	ceuse(s) and ma deta and placa,	innar as stated. and due to the cause(s)
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Months Devs Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Deys 1₩ 2□ F Hours 169-24-8812 68 Yrs. July 10, 1930 unknown Usuai Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore City Baltimore 1 ☑ Yes 2 ☐ No 10e. Street end Number 10f Zip Code 10g. Citizen of Whet Country? 700 W. 40th Street 21211 U.S.A. 12. Wes Decedent Ever in U.S. Armed Forces? UNKNOWN 11. Maritet Status 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Baca - American Indian 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) unknown unknown 19e. Informents Name/Relationship Warde rint) Director 195 Mailing Address (Street and Humber or Rugat Boute Number Gitz of Town Stots Zin Godd Baltimore, Maryland 21201

20b. Plece of Disposition (Neme of commetery, cremetory or other place)

Dete 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 □Donetion 5 ☑Other (Specify) in state 21. Signature of Funeral Service Licensee. Wade, Director 235 tested Attatolity Board, 655 W. Baltimore Street Baltimore, Maryland 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Finel disease or condition resulting in deeth) NEUMONIA Due to (or es a consequença of): MARATION Due to (or es a consequence of): Due to (or es e consequença of): 23b. Did tobacco use contribute to the cause of death? ENCEDAMOPATHY 1 Yes 2 No 3 Probably 4 Unknown 24e. Wes an eutopsy performed? FISHLLATION 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner Examiner

physician and the burial-transit

attanding p

signed by the atta

page 2 has cartificata

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director, I

Physician/Medicai

Completed by

Be

Certification: To

Medical

The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

p

Completed

Be

7 is marked other than "natural", or items 23a or 28a-f shov treumatic event, the Medical Examiner must be multified at

permit. Pagas I and 2 should be filed within 72 hours after Department of Haaith and Mantai Hygiene. Important: If Item 27 Is marked other than "natural", or has any injury or other traumatin.

Baltimore, Maryland 21215-0020

the Maryland

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

28. Plece of Deeth (Check only one)

25. Wes case referred to medicel examiner?
1 Yes, 2 No Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 DER/Outpetient 3 DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Ptece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner steted. 29a, Certifier 29b. Signeture and title of certified 29c. License number 29d. Date stgned (Month, Day, Year)

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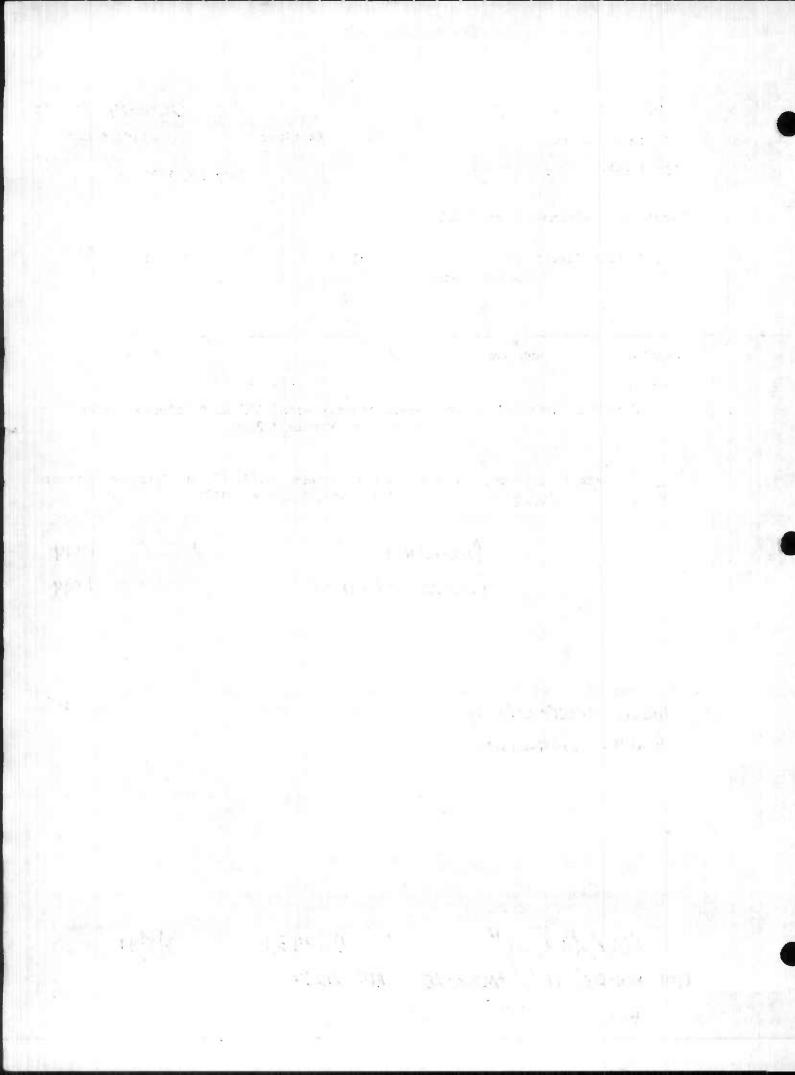
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ouse of deeth (ttem 23e) (Type, Print) NCHARLES BALTIMURE 31. Dete filed (Month, Dey, Year)

State Registrar

MAR 1 9 1999

32. Registrer's Signeture

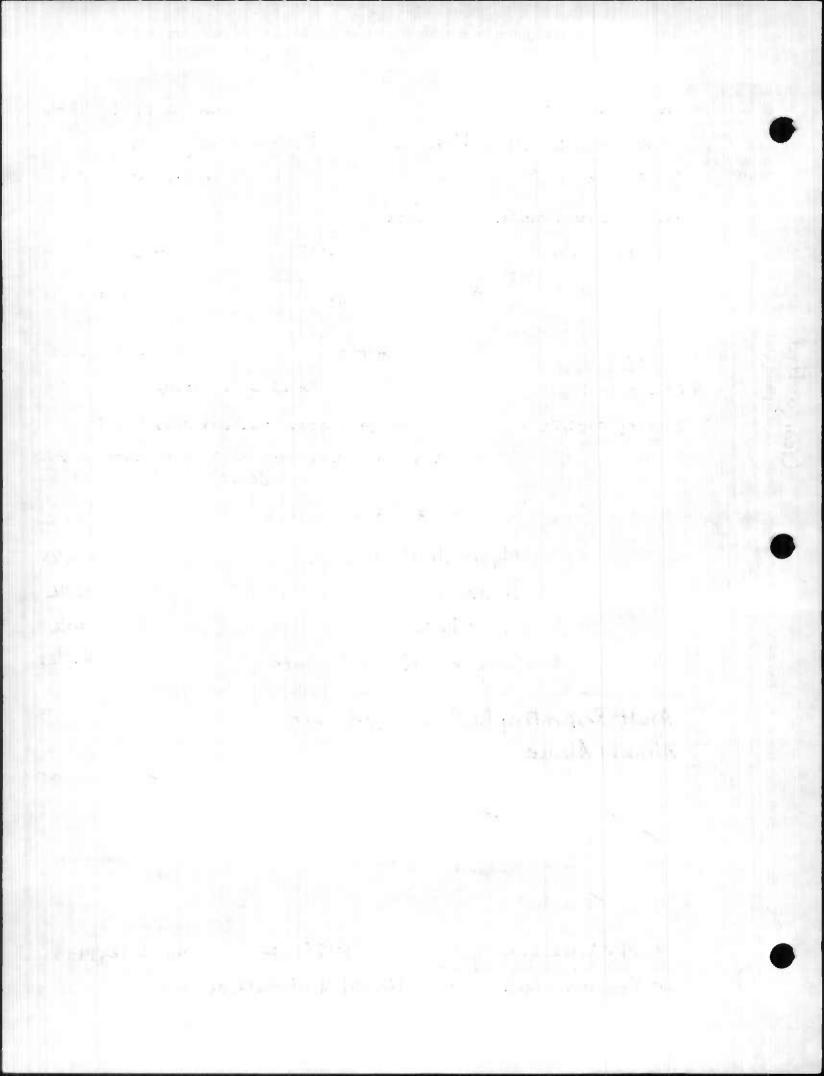


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician March 2,1999 George W. Ford 1846 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fedility Neme (If not institution, give street end number) Examiner Bullimore City Bath more N/A Hospital if Under 1 Year | if Under 24 Hrs. 5. Social Security Number 8. Dale of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** Months Days Hours Min 15M 20 F Yrs. 216-22-3506 69 Director 27,1929 Md. Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limita 1 ☐ Yes 3 ☐ No Pasadena Md. Anne Arundel other than "natural", or herne 23e or 28a-f a ent, the Medical Examiner must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ä 628 Cyril Ave. 21122 U.S.A Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Dates: Was Decedent of Hispanic Orlgln? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Black, White, etc. 11. Maritel Slatus 1 Never Merried 20X Married 1 Yes 2€No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Waterman Crab and Oyster 10 reportant: If Item 27 is marked other 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be George W. Ford Estella C. Wood 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 628 Cyril Ave. Pasadena Md., 21122 Dorothy Ford/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 Donation 5 Other (Specify) Glen Haven Mem. Park 3/15 Glen Burnie, Md. 22. Name and Address of Facility CONCE FUNERAL HOMF 21. Signature of Funeral Service Licensee public etions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

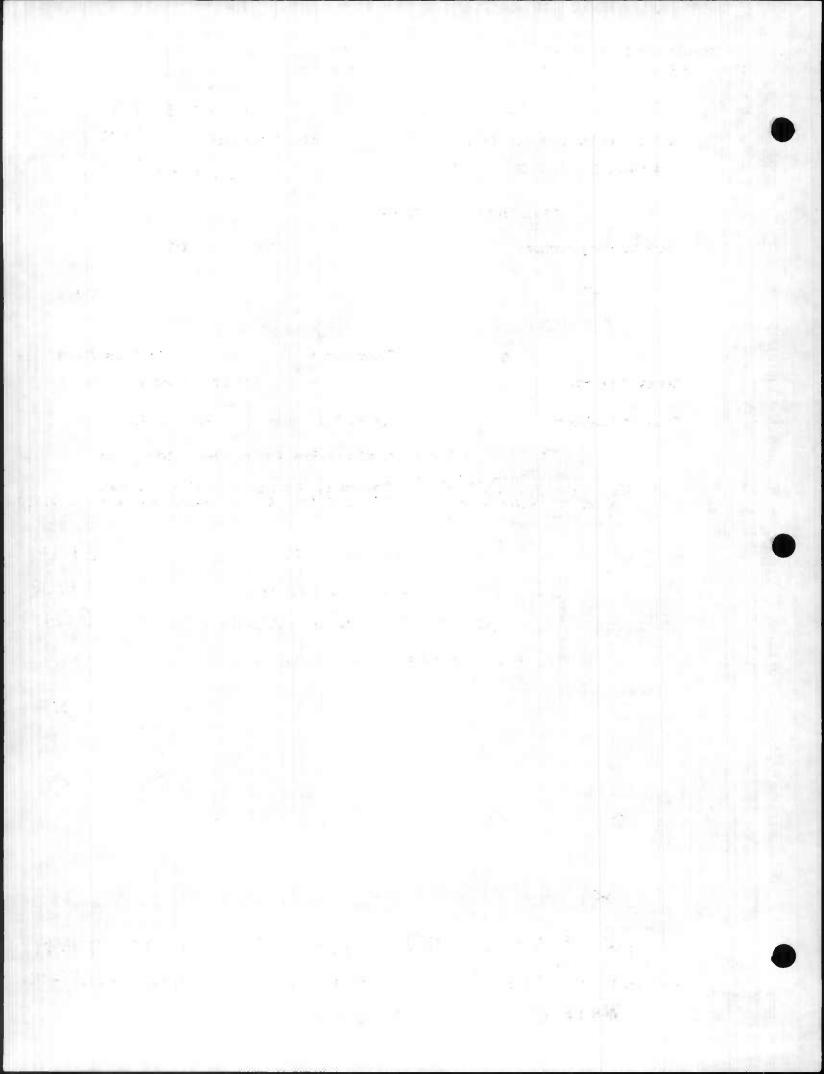
Approximate 2.1 Part1. Enter the disease, or conshock, or heart failure. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Completed by Physician/Medical Examine neumonia The law requires that the daath certificate be executed attanding physician and for use as the bunal-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Failure Division of Vital Records, P.O. Box 68760, Kenal 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown Adult Respiratory Distress Syndrome 24b. Were autopsy findings evellable prior to completion of cause of death? 24a. Was an autopsy Alcohol Abuse 1 Yes 2 No 2 1 No 1 Yes cartificata or Attending Physician: 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA Tol Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this of funeral dir 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28c. injury at Work? 5 Pending investigation n 24 hours aftar death.

Ne Funeral Director: Af
pletaly filled in by the fu 1 Yes 2 No aftar death. 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital 29a. Certifier (Check only one) 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end manner es stated Medical 2 Medical Examiner: On the basis of exeminetion and/or investigetion, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) end menner steted. To the Vithin 2 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number March 12,1999 30. Name and address of person who completed ceuse of death (item 23a) (Type, Print) 6 Sinai Bonasera Hospital 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State MAR 1 8 1999 Registrar **DHMH 16 Rev 6/95**



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-0020	d within 72 hours afti lians. r than "natural", or i the Medical Exami	þ	1 ☐ Never Marri 3 ☐ Widowed		Yeer or I	ive Detes:TO 19	45	1 Yes 2 No			Speci	MUT		
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Baltimore,	permit. Pages 1 and Department of Health Important: if item 27 any injury or other tr once.		4 Donetion	Cremation 3 5 Other (Spe		01-1-	cemetery, cn	position (Neme of emetory or other pla ARK CEMET	ERY	3/20/99		Location - City or Town, Stete ALTIMORE, MARY		
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1	Physician /Medical Examiner	er	Immediate Cause (disease or condition resulting In death)	Finel	e	en to	1 Ch	equence of):	Fibri	llati	ON		Onset end Deeth	
(bur 5	tilicate be executed g physician and as the burial-transit	edical Examiner	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or that initiated events resulting in death) L	nditions, mediate rlying Injury	b		or as e conse							
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ofv	Physician: This certific ral director,	2	examiner? 1 ☐ Yes 20				ER/Outpetie	ent 3LI DOA		Home 5 Resi)	
Q 10	Attending ir death, ector: After by the fune	Certification:	1 Naturel 2 ☐ Accident 3 ☐ Suicide	5 Pending Investiga 6 Could no determin	t be 28e. Plac	ury at ork? Yes 2 No	28d. Describe how injury occurred 1 No 28f. Location (Street and Number or Rural Route Nu							
NAME: Divis	hours afte meral Din y filled in		4 Homicide 29a. Certifier (Check only	1⊠ Certifying	Physician: To the	ling, etc. (Specif	wledge, dea	ath occurred et the t	lme, dete end pla	City or To	cause(s) and m	anner as ste	ated.	
	To the Ho within 24 To the Fu	Medical	one) 29b. Signeture end		end mer	pasis of examine nner stated.	tion end/or l	nvestigation, In my	opinion, deeth or	curred at the time,	29d. Date sign			
	X	1) w	W a	Ke Me	edical	Doct	ov P	12750	i l	March	18,1	999	

State Registrar

Horlali Nutakor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

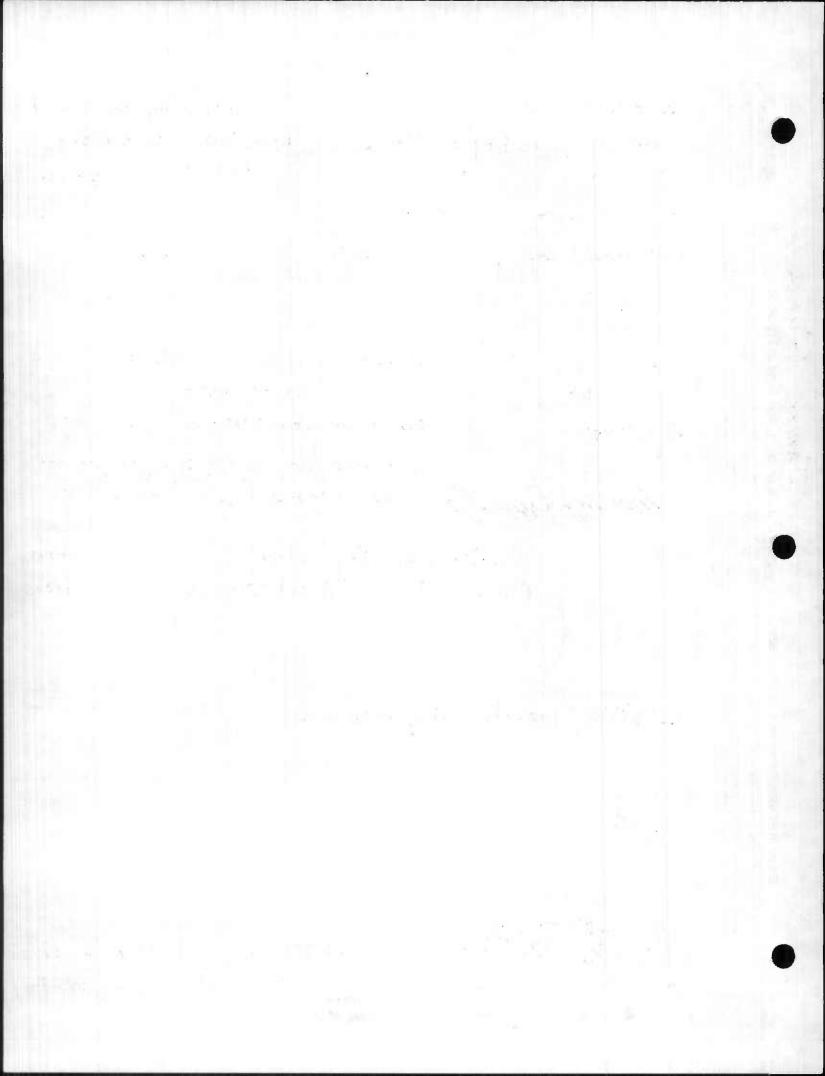
St. Agner Hospital, 900 Caton Avenue, Baltimore, Maryland 21229



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:14 AM 1999 James Joseph Gurgick 4c. County of Death March /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) **Examiner** sedale Baltimore Franklin Square Hosbital Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex ge (In yrs. last birthday) **Funeral** Deys 1₩ 2□ F Months 84 187-07-9383 Director Pennsylvania Usual Residence of Decedenf 10c. City, Town or Location 10a State 10h County 10d, Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show irsumstic event, the Medical Examiner must be nutrited at MD Baltimore Baltimore 1 ☐ Yes 2 ☐ No Director 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? TURGICI 21237 U.S.A. 6000 Kenwood Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedenf Ever in U,S. Armed Forces? 14. Race - American Indien, 11. Marital Stafus Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 □ Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) WJZ T.V Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be 2 should be fi Pages 1 and 2 should 2 James Gurgick Margaret Draina ames 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6000 Kenwood Avenue Baltimore, Maryland 21237 mportant: If item 27 any injury or other to Mary Gurgick 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 0 1 Duriel 2 Cremetion 3 Ramovel from Sfate 4 Donetion 5 Other (Specify) Gardens of Faith Cemetery 3/20/99 Baltimore, Maryland 22. Name and Address of Fecility Dippel Funeral Home Inc. 21. Signature of Funeral Service Licenses 7110 Belair Road Baltimore, Maryland 21206 Approximete Interval Between Onset and Deeth death. Do not enter the mode of dylng, such as cerdiac or respiretory arrest, **Physician** /Medical Immediete Cause (Final Hour disease or condition resulting in deeth) Examiner Examiner ears physician and the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or es e consequence of) attending for use as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yss 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings evailabla prior to completion of cause of death? 24a. Wes en autopsy s need Completed is certificate had 2 No 1 ☐ Yes 2 ☐ No 1 Yes Hospital or Attending Physician: 25. Wes case referred to medical exeminer? Be 28. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral Certification: 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? After 1 Natural
2 ☐ Accident 5 Pending Investigation 1 Yes Director: A 3 Suicide 6 Could nof be Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 I Homicide within 24 hours aft To the Funeral Di complataly filled in 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of exemination end/or investigetion, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29e. Certifier Medical To the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and the continue leted ceuse of death (Item 23a) (Type, Print) juare Drive Baltimore, Maryland 2/237 9000 Franklin Sa Thomas 31. Dete filed (Month, Day, Year) WAR 19 1999

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death GILL **Physician** VERA 9:00 PM MARCH 1999 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner mn HOSPITAL, LOCHRAKEN 21239 LALTIMIRE SAMARITAN 0000 5. Social Security Number If Undar 1 Yaar | If Undar 24 Hrs. Months Days Hours Min. Birthplaca (Stata or Foreign Country) 6. Sax 7. Aga (In yrs. last birthday) **Funeral** 2181200 1 ☐ M 2 🕅 F Oct. 5, 1914 Director 84 Maryland Usual Rasidenca of Decedant the Marylend 10a. Stata 10d. Insida City Limits 10b. County 10c. City. Town or Location 28a-f show r than "natural", or items 23s or 28a-f shov the Wedical Examiner must be notified at 1 Yas 2 □ No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? death with 2211 West Rogers Avenue 21209 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armad Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 14. Race - Amaricen Indian, Black, Whita, atc. 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 11. Marital Status filed within 72 hours efter 1 Nevar Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White þ 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retirad) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) permit. Peges 1 and 2 should be filed will Department of Health end Mental Hygienn important: If frem 27 Ia marked other the eny lijury or other traumatic avent, the British in the contract of the contract of the process Dental Assistant Baltimore City 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Ralf E. Humphreys India W. Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straet end Number or Rural Routa Number, City or Town, Stata, Zip Coda) Darryl Gill (son) 1000 West 38th Street, Baltimore, Maryland 21211 20b. Place of Disposition (Nama of cematary, crematory or other placa) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 X Burial 2 Cramation 3 Ramoval from Stata Parkwood Cemetery 3/22/99 4 ☐ Donation 5 ☐ Othar (Specify) Baltimore, Maryland 22. Nama and Addrass of Facility A. Alan Seitz, Jr. Funeral Home 21. Signatura of Funeral Sarvice Licansaa 3818 Roland Avenue, Baltimore, Maryland 21211 23a. Part1. Enter the di aasa, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. Approximete Interval Batween Onsat and Death **Physician** Immediate Cause (Final disaase or condition resulting in death) /Medical neumonia Examiner Physician/Medical Examiner RENAL STAGE DIJEASE ed by the attending physician end detached for use as the burial-transit certificate be executed Sequantially list conditions, if any, leading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury DIABLE FES Box 68760. MELLITUS that initiated avants Dua to (or as a consequanca of) rasulting in death) Last The law requires that the deeth P.O. Part ff. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown Division of Vital Records, by 24b. Wara autopsy findings avelleble prior to complation of causa of deeth? 24a. Was an autopsy Completed been s this certificate has 1 Yes 2 No 1 ☐ Yas 2 ☐ No Physician: 25. Was case rafarred to medicel axaminar? Be 26. Placa of Death (Check only ona) To Hospital: 1 Minpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 ☐ Yas 2 XNo funeral 27. Mannar of Daath 28a. Data of Injury (Month, Dey Yaar) 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? Certification: After t 5 Pending Invastigation Attending 1 Naturei To the Hospital or Attending ithin 24 hours aftar deeth.

To the Funeral Director: Afta completely filled in by the fun 1 Yas 2 No 2 Accidant 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated.

2 Madical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edicai 29a. Cartifian (Check only one) 29c. Licensa number 29d. Data signad (Month, Day, Year) 29b. Signatura and titla of certifier CHAWLA, MD

SAMBRITAN HOSPITAL BACTIMORE MD

State Registrar

30. Nama and addrass of person who completed cause of deeth (Item 23e) (Type, Print)

MD

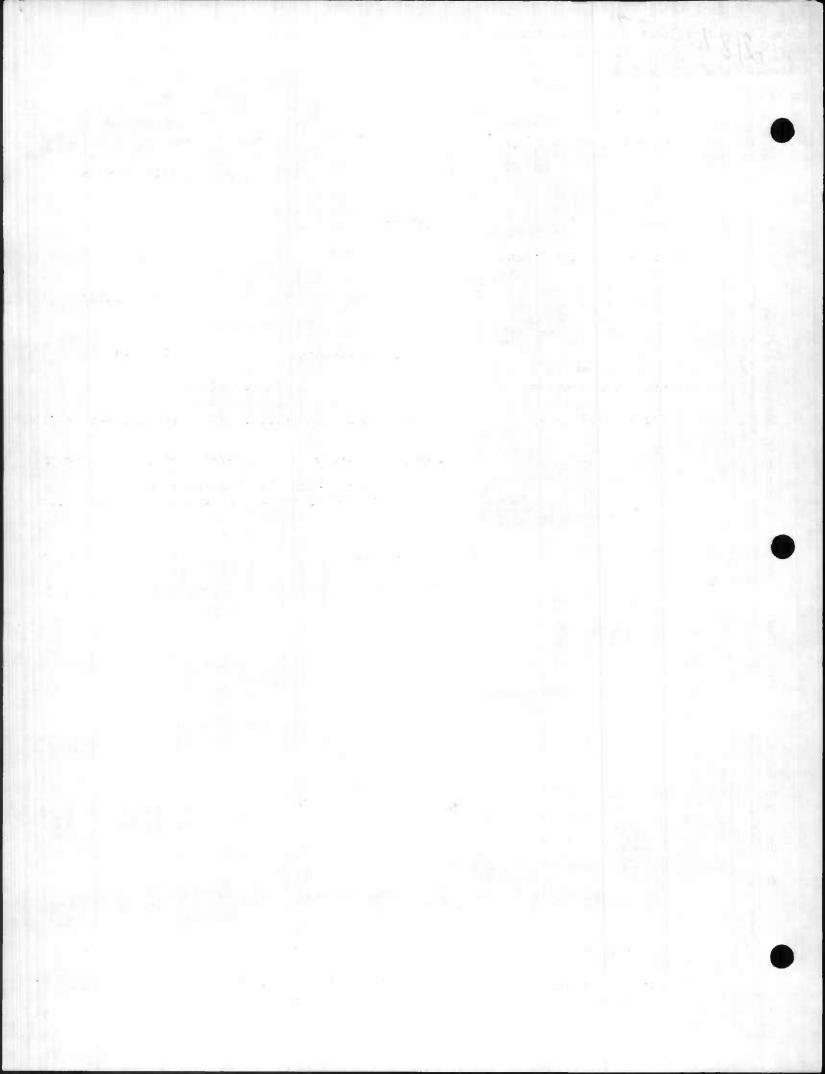
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32 Registrar's Signatura

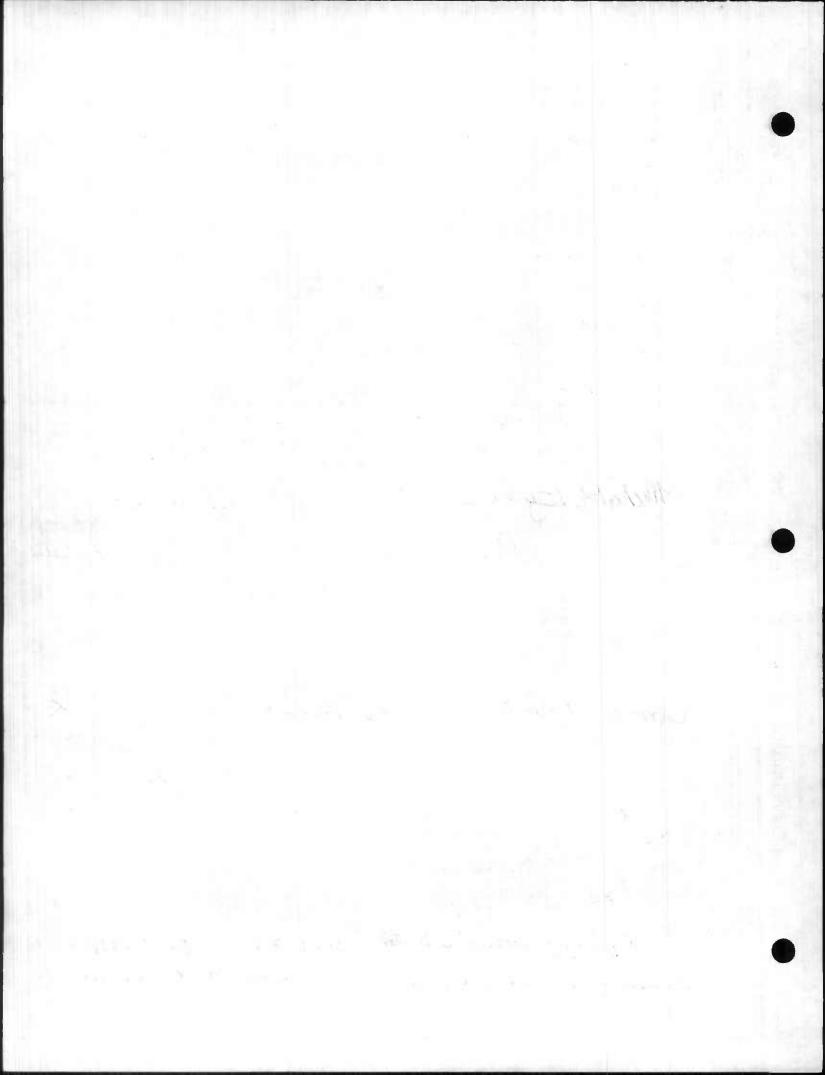
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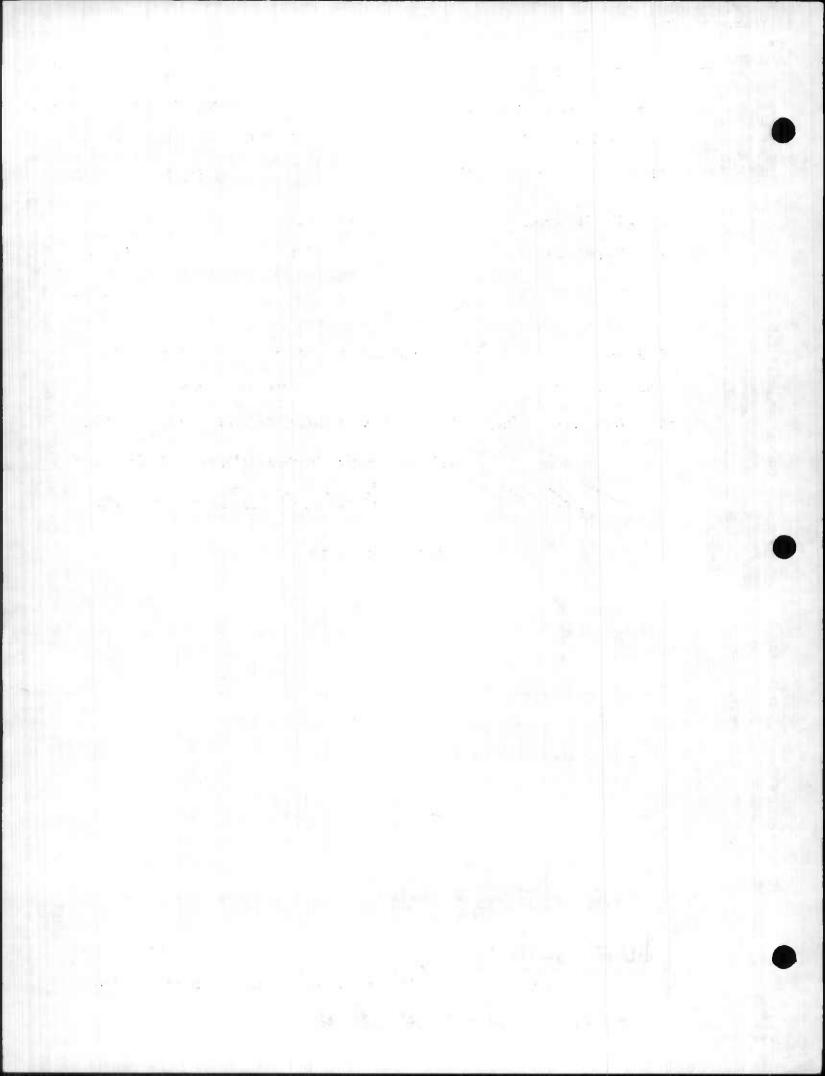
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	عادث				State of	Marylar		ertificate of	dealth and M Death		gieneg 9 Reg. No.	0 (3940		
П	Physicia		1. Decedent's Name							2. Date of De Month	Day	Year	3. Time of Death		
E.	/Medica	al -		C. Garr			-17		4b. City, Town, or Lo	March		1999	3:30 P.M.		
	Examine	r	4a Facility Name (# Knollwoo			177			Millersv:		4c. County		de1		
	Funeral Director		5. Social Security N 424 14 73	umber 6.		Age (In yrs. 73	last birthda Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, De	h y. Year)	9. Birthp	lace (State or Foreign		
	-	-	Usual Residence of	Decedent						April 12, 1925 Alabama					
	th the Maryand or 28a-f show a notified at	_	10a. State	10b. County			ty, Town or I	Location				1	Od. Inside City Limits		
	the Ma	Director	Maryland		George's	Во	owie						★QYes 2□No		
	Man Park		10e. Street and Nun	nber				10f. Zip Code		35.73	10g. Citizen of V	en of What Country?			
	s 23s	era	4811 Bria	arcrest (Ourt 12. Was Deced	lant Ever in 1	10 12	207		noity Vac or No		ed States . Race - American Indian,			
020		by Funeral		ed 2 Married 4 Divorced	Armed Ford 15 Yes 2 If Yes, Give Year or Det	es?	III	If Yes, specify Cub	Decedent of Hispanic Origin? (Specify Yes or Ns, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 No Specify:			Specify: Whit			
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12			12 17. Father's Name (OFFICE Addition to an	4		FILL	italy	18. Mother's Name	Cina Middle			es Navy		
and	2302 0	To Be			,					Chand1		10)			
Ž	Maryin nd 2 should th and Ma 27 is marks r traumatic		Emery C.		(Type Print)		19b Ma	iling Address (Street	and Number or Run			State Zin	Code)		
Ma			Patricia			er		st Ct. Bo				0000)			
ore,	-115		20a. Method of Disp	position			Place of Disponentery, cr	position (Name of	ce) March	Pate 199	20c. Location -	City or To	wn, State		
Ĕ	Pages nert of mt: If Ib ary or o			☐ Cremation 3 [5 ☐ Other (Speci		Je	ffers	on Memori	al	.0, 1)	Trussv	ille	AL		
Baltimore,	Departs Departs Imports any inju	- 1	21. Signature of Fu	1 / /	1 ()	,		22. Name and Addre		eral Ho	me, Inc	•			
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	Examiner		resulting in death)		a			equence of):		T					
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,	physician and physician and s the burial-transit	dical Examiner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or	nditions, mediate		Due to (d	or as a cons	equence of):							
8760,	ysicial	20	frigit williated exertity		с.	Due to (c	r as a conse	equence of):							
w	the death certificate be executed by the attending physician and sched for use as the burial-transit	Med	resulting in death) L	.ast	d			i							
Box	that the death certified by the attending deteched for use a	Completed by Physician/Me	Part II. Other elanifi	cant conditions	contribution to doe	th but not ree	ulting in the	underlying cause gi	uen in Parkl	23h Did	Johnson une co	ntribute to	the cause of death?		
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/ita	Physician: this certific ral director.	90	25. Was case referr	ed to medical	11.1.1.1.1.1			l a	26. Place of Deat	h (Check only o	ne)				
of	Physic this c	2	1 Yes 2					ent 3LI DON			dence 6 □Oth	-	y)		
uc	After funer	Certification:	27. Menner of Death 1 Z Natural	5 Pending investigation	28a. Date of (Month,	Day Year)	28b. Time tnjury	Wo	ry at rk? Yes 2 □ No	28d. Describe	now injury occur	red			
isi	after death. Director: After	I Ca	2 Accident 3 Suicide	6 Could not b	e con Diana	(Injury - At h	ome, farm, s	street, fectory, office	1100 2 0110	28f. Location (Street and Numb	er or Rure	I Route Number,		
<u>S</u>	after after d in b		4 Homicide	Getermined	building	, etc. (Specil	y)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tox	vn, State)				
	To the Hospital or Attending Physician: The intuin 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier (Check only one)	Certifying Pt	nysician: To the bas niner: On the bas and manne	is of examina	wledge, dea ition and/or	ath occurred at the ti investigation, in my o	me, date and place, opinion, deeth occurr	end due to the red et the time,	cause(s) and made dete and place,	anner as s and due to	tated. o the cause(s)		
	2728	29b. Signature and title of certifier Whyniae MD Attending Doctor D21684 3-15-1998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C-V. CYRIAC. M.D F109 RITCHIE AWY, PASADENA, MD 21122											Day, Year)		
1	Ust 1		30. Name and addre	ess of person who	completed cause	of death (Her	n 23a) (Type	Print) AWY	PASAL	ENA,	MD &	112	2		
	State		31. Date filed (Monti		32. Reg	gistrar's Signa	ature								
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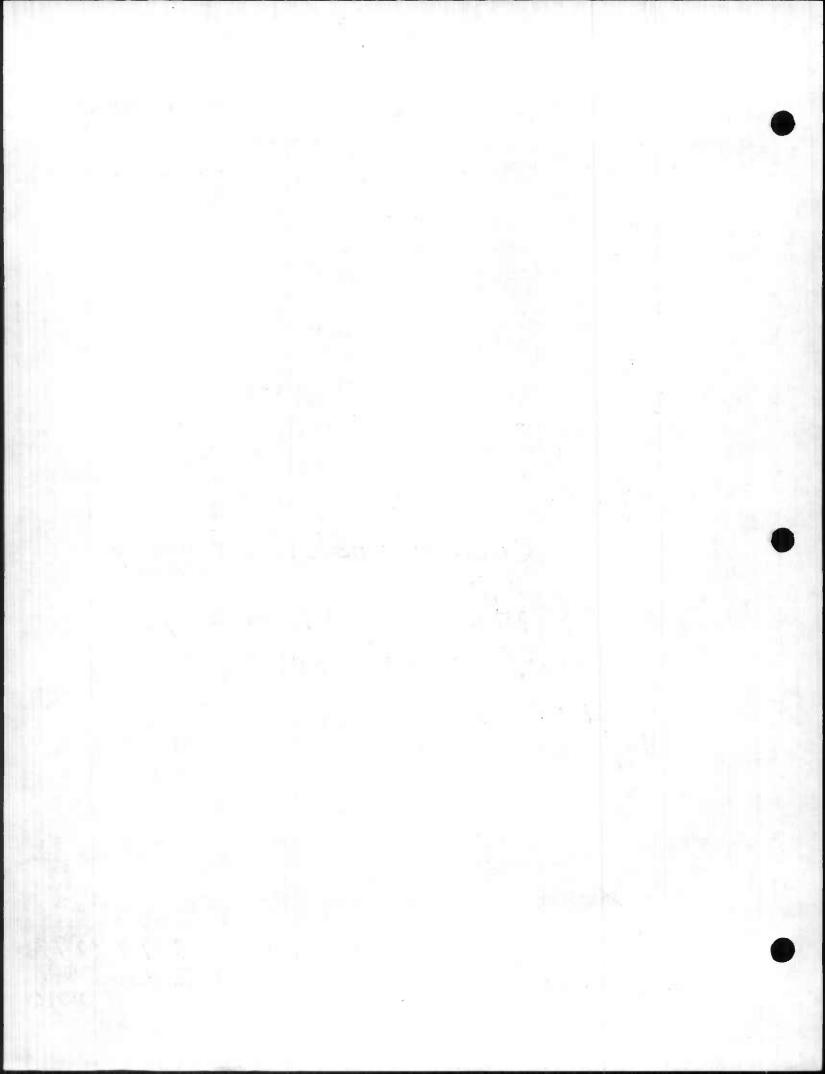
RAYMOND GEBHERDT	ITEN	1S: #23 PART I, 27 PER M	State of M						and M		giene 9	08	3941	
GEBHERDI		Decedent's Name (First, Middle, Last)		00-33	WIX.	011111041				2. Date of Dea	ath		3. Time of Death	
Physi		Raymond Stephen	Gebhardt	, Sr.						MARCH	15, 199	Year 99	14:25 PM	
/Med Exam		4e Fecility Neme (If not institution, give s JOHN HOPKINS BAYV)				4b. City, To		cation of Death	,	of Death		
Funera Directo		213-14-8294		ge (In yrs. 78	last birthda Yrs.	Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day Dec. 3	, Year) 1, 1920	9. Birthpl Count Ma	ece (State or Foreign try) ryland	
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n with the 3s or 28s	Funeral Director	10e. Street and Number 4261 Chapel Road					Code	1128			10g. Citizen of \	What Count		
15-0020 n 72 hours effer death with the Marylend "naturest", or items 23s or 28s-f show	by	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 Yes 2 If Yes, Give Year or Dates:	No No	If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1 ☐ Yes 2 ☒ No Specify: Spe						14. Rac Blac Specify	Race - Americen Indian, Black, White, etc. Crify: White		
THE R. P. LEWIS CO., LANSING, MICH.	Completed	15. Decedent's Educ (Specify only highest grade Elementery/Secondery (0-12) 10th Grade		16e. Decedent's Usual Occupation (Give kind of work done during mos						ing	16b. Kind of Br			
rland 2 uld be filed Aental Hygirked other tic event, ti	Maryland nd 2 should be fill the end Mental H 27 ta marked out r treumatic even	17. Fether's Name (First, Middle, Last) John Gebhardt			18. Mother's Nem Caroly									
Mary and 2 shot alth end N		19a. Informant's Name/Relationship (Ty) Mrs. Linda Janes	oe, Print) (daught	er)							or, City or Town, ity, MD			
Baltimore, semit. Pages 1 el Department of Heam portants if Item in y Injury or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R □ Donation 5 □ Other (Specify)	emoval from State	C	emetery, c	sposition (Netremetory or of Memor	other pla		ns 3	Date / 19/99	20c. Location - Bel Ai			
Balti permit. Departri importa	and a	21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complishock, or heart failure. List only or				22. Name er	nd Addre	ess of Facilit	ty					
Physician /Medica Examine	i r	immediate Cause (Final disease or condition resulting in death)	e cause on each I	DI	LATED	CARDIOM'	YOPAT					1	Interval Between Onset end Death	
cords, P.O. Box 68760, requires that the deeth certificate be executed been signed by the ettending physician and should be deteched for use as the buriel-transit	cai Examiner	Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events				sequence of):								
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on of Vita ding Physician: h. After this certific	tion: To	1 ☑ Yes 2 □ No □ □ 27. Manner of Death 1 ☑ Natural 5 □ Pending 2 □ Accident □ Investigation	ospital: 1 ☐ Inpati 28a. Date of Inj (Month, Di	ury	ER/Outpat 28b. Time Injur	tient 3 De	28c. Inju				dence 6 DOth		y)	
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Division of To the Hospital or Attending Phywithin 24 hours eiter death. To the Funeral Director: After this completely filled in by the funeral	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as 27 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due on manner stated.										and due to	the cause(s)	
To the to the common	2	290. Signature and title of certifier	29	29c. License number			29d. Dete signed (Month, Dey, Year)							
		30. Name and address of person who co	mpleted ceuse of	deeth (Iten				ME eet R	al+i	more N	MARCH			
		31. Date filed (Month, Day, Year)	32. Regist	anda Ciana		r Cilli	مسر	CC, D	للها للله	altimore, Maryland 21201				



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State of Maryland / Department of Health and Mental Hygiene 9 08942

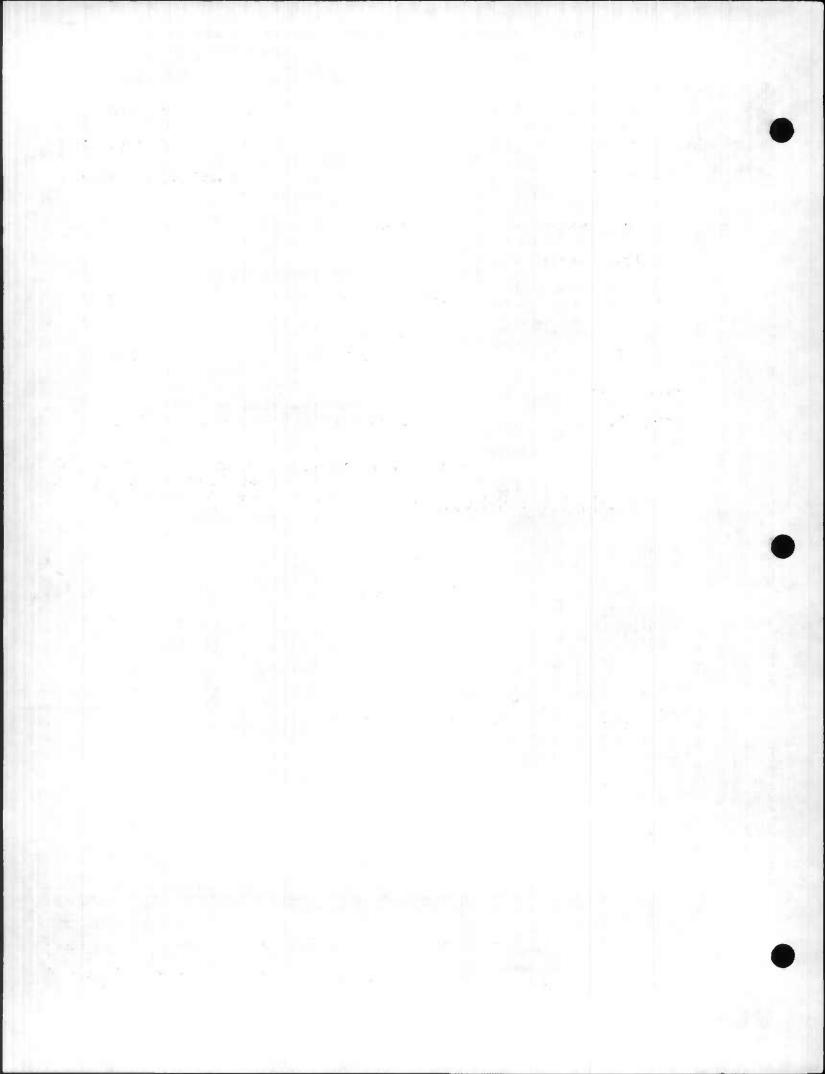
	Certificate of Dea	th	Reg. No.	46
81	1. Decedent's Nama (First, Middle, Last)	2. Date of Do Month	Day Vara	ima of Death
Physiciai /Medica	14 X X X X X X X X X X X X X X X X X X X	Mar	16 1999 /.	: 45AM
Examine	4a Facility Name (If not institution, give street and number) 4b. City	, Town, or Location of Dear	h 4c. County of Death	
	75.0	Hiredre	NIM	
Funeral	Months Days Hou	der 24 Hrs. 8. Data of Bi		State or Foreign
Director	219-67-66 99 1 M 205 76 Yrs. White Decedent	Oct 8	1922 S.Caro	lina
9 ku	10a. Stata 10b. County 10c. City, Town or Location		10d. Ins	side City Limits
Mary Mary Mary	Manuface N/B Baltimera		12	Vas 2□No
28s	10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?	
the of the	2769 W. North Ave 21216		USA	
Cine 2	11. Merital Stetus 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic	Origin? (Specify Yes or N	o- 14. Race - Amarican Ind	lian,
O se se o			0/	,
002	3 Widowed 4 □ Divorced Yaar or Dates:	cify:	Specify: 15/acl	1
5-0020 72 hours a natural, or dical Exam	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 17. Father's Nama (First, Middle, Last) CHES TEN PENKINS 16a. Decedent's Usual Occupation (Give kind of work done during relief) (Give kind of work done during relief) (HES TEN PENKINS 18. Middle, Last)	most of working	16b. Kind of Business/Industry	
2121 d within pens. r then	Elementery/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)		Giroy Hosp	ihel
C Bush	12 years NUISES HID.		1	7100
STEED STEED	17. Father's Name (First, Middle, Lest)	othar's Nama (First, Middle		
Tyle Market		PAULINE 1		
Ma 12 st 1 s and 1 s a	19e. Informant'a Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Nu	01	er, City or Town, State, Zip Code)	
Hoall and	20e. Mathod of Disposition 20b. Place of Disposition (Name of	Dete Dete	20c. Location - City or Town, St	Late
TO SERVICE OF TOTAL	Buriel 2 Cremetion 3 Removal from State cemetery, crematory or other place)	1 3-20-99	Brooklyn, K	2 d
Him Parket	4 Donation 5 Other (Specify) (SDAR HILL CEMENT	EALI		
B B B B B B B B B B B B B B B B B B B	21. Signature of Fuperal Sarvice Licensee 22. Name and Address of Fa	Erstown PM	n - Hom's teno	sor marc
	BALTOMORE,	her DID		
	23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.	es cardiec or raspiratory	rrast, Appro	oximata val Between ot and Death
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Examiner	resulting in death)	piece in	monay	
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ords, P.O. Box 68760, requires that the death certificate be as signed by the attending physician hould be detached for use as the buriand by Dhysician and hy Dhysician and hy Dhysician and addicated	Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of):	1. 1-		
X Ging ding	L. CIIIC DAMER	16/15		
Box eath cer attendir for use				
P.O. that the de by the detached	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pro		tobacco use contribute to the c	
The law requires that the death ce tale has been signed by the attendity page 2 should be detached for use	Peripheral artend DISRASE	19	Yea 2 No 3 Probably	4 Unknown
rds n sign	Hills old tout his	24a. Was	an autopsy 24b. Ware aut	topsy findings
cord w requir been s should	Typercrops record min	perf	ormed? available completic of death?	on of cause
The law		,,,		2□ No
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ision of the funeral y the funeral	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident Invastigation M 1 Year	≥□No		
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thin 2, the post of the post o				
5 × 5 × 5	29b. Signeture and titla of certifier 29c. License numb	17/	29d. Data signed (Month, Day, Y	290
	11. X D144	16	5 / 9 / 1	17
1 3	30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)	Blrd	Baltimone	MI
The state of the s	31. Data tiled (Month, Day, Year) 32. Registrar'a Signatura,	13110,	1700 11 CINON	191/
State Registrar	MAD 1 0 1000		2	916



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Decodors Have first Mode, Last Spring					Ce	ertificate of	Death	Re	eg. No.			
Frank J. Gorden Sr. March 1997 1/107/107/107/107/107/107/107/107/107/10			1. Decedent's Name (First, Middla	, Last)						V	3. Tima of Deeth	
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20. Meyend of Disposition of Superation State 20. Location - City or Town, State	and	and h						Code)				
A State		5 - 5	Joseph F. Gorde	n - Son	208	Mill Har	bor Driv	e, Arnold	I, MD 21	012		
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2 Accidant 3 Suicide 4 Homicide 28e. Plece of Injury - At home, farm, streat, fectory, office 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 29e. Certifier (Check only one) 10 Certifying Physician: To the basis of examination end/or Investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner estated. 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature	0 4	neral n:		28e. Dete of Injury	28b. Time	of 28c. Inju	iry at	28d. Describe ho	ow injury occurre	ed		
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29e. Certifier (Check only one) 29e. Certifier (Check only one)	VIS	Py th	dotormi	200. PIECE OF INJURY	- At home, farm, s	treat, fectory, office		28f. Location (St	reet end Numbe	or Aura	I Routa Number,	
29e. Certifier (Check only one) 29e. Certifier (Check only one)	2	din din	4 C Homicide	building, etc. (<i>эрөспу)</i>			City of Yow	i, State)			
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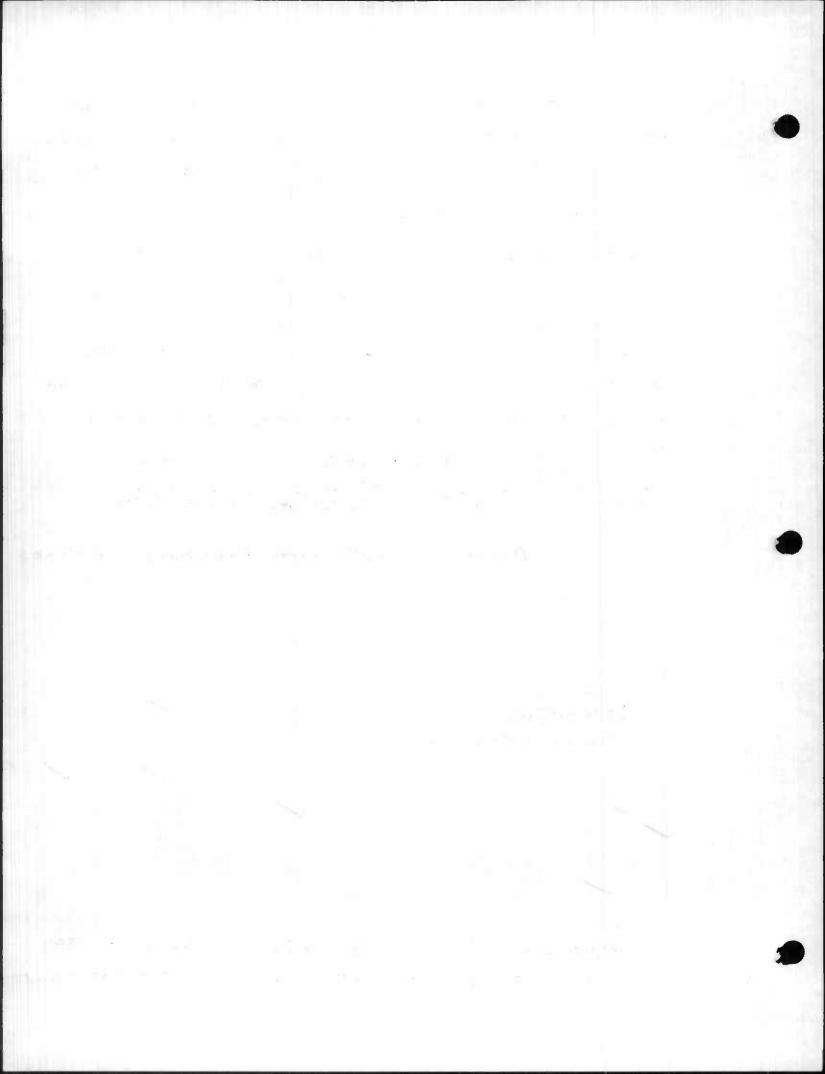
State of Maryland / Department of Health and Mental Hygiene 9 (8944)

						Cei	tificate o	f Death	F	Reg. No.	00	
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E	xamin	er	4a. Facility Name (If not institution, GENESIS ELDERO			ANE		4b. City, Town, or BROOKLYN		4c. County ANNE		DEL CO.
	neral ector		220-07-4714	3. Sex 7. Ag	ga (in yrs. 86	last birthday) Yrs.	If Under 1 Yes Months Day		8. Date of Birth (Month, Day May 13	(, Year)	9. Birthple Count Mary	eca (Stata or Foreign 'Land
pue	-		Usuel Residence of Decedent 10a. Stete 10b. County		10c. Cit	y, Town or Lo	cation				10	Od. Insida City Limits
Mary	uffed a	ctor	Md. n/a	ı	Ba	altimor	re					1 Yas 2 No
oth with the	unt be no	ral Director	10e. Street and Number 1509 Clarkson	Street			10f. Zip Code	230		10g. Citizen of V	Vhet Count	ry?
hours efter death with the Maryland	Example of many be notified at	by Funeral	11. Marital Status 1 Never Merried 2 Marrie 3 Widowed 4 Divorced	Armed Forcas? 1 Yes 2 X	12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 → No 1 Yas, Give Yeer or Dates:			13. Was Decadent of Hispenic Origin? (Sp. If Yes, specify Cuban, Mexicen, Puerto			e - Amarice k, White, e	
72 hours	Marical E		15. Decedant's	Education		16a. Deced	lent's Usuel Occ	upetion		16b. Kind of Bu	Specify: white	
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		Charlotte Kell	Ly (Daug				on Street	T				
		20e. Method of Disposition 1 Description 2 Cremation 3				sition (Name of natory or other p	1	Dete	20c. Location -			
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requires seen sign hould be		Completed b	COLor	1 CARC	_1~	OMA			24a. Was e perfor		con	re eutopsy findings illeble prior to appletion of ceuse laeth?
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Attending or deeth. actor: After by the fune		27. Mannar of Deeth 1 ☑Naturel 5 ☐ Pending	28e. Deta of Inju (Month, Da	ry Year)	28b. Time of Injury	28c. Inj		28d. Describe h	ow injury occurr	ed		
	Certification:	2 Accidant Investige 3 Suicida 6 Could no 4 Homicide determin	ot be 200 place of this way At home from short feature office.							Route Number,		
Hospital of 24 hours elemental D		edicai Ce	(Uneck only 2 Medical Ex	Physicien: To the best	of my kno	wledge, deeth	occurred et the	tima, dete end plece	, end dua to tha c	eusa(s) and ma	nnar es sta	atad. tha causa(s)
456	9	Ned Med	one) 29b. Signature apertifie of certifier	and manner st	ated.			nsa number				
1	1		1 Spile	ide	Mo					29d. Dete signed		
1/20			30 Name end eddress of person w	no complated causa of d		23a) (Type,	Print) HE	HUVER	ST B	AUTIN	NORG	1999 5 21225

State Registrar ed (Month, Day, Year)
MAR 1 9 1999

52. Ragistrar's Signature

Sparks



certificate has t I director, this funeral After

Division of Vital Records, P.O. Hospital or Attending Physician: after death Director: / d in by the f 24 hours aft Funeral Di letely filled in

Port,

To the 1 To the 1

Registrar

P

Certification:

Medical

29b. Signature and title of certifier

6 Could not be determined

investigation

28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Frank 130-p

1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury at Work? 1 Yes 2 No

street

subject beaten 281. Location (Street and Number or Aural Boute Number. Ave. City or Town, State) 4 3 W. Belair Ave. Baltimore, Ha 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

29c. License number OCME

29d. Date signed (Month, Day, Year) MARCH 8, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hute, mg 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

XYes 2 No

27. Manner of Death

1 Naturai

2 Accident

3 Suicide

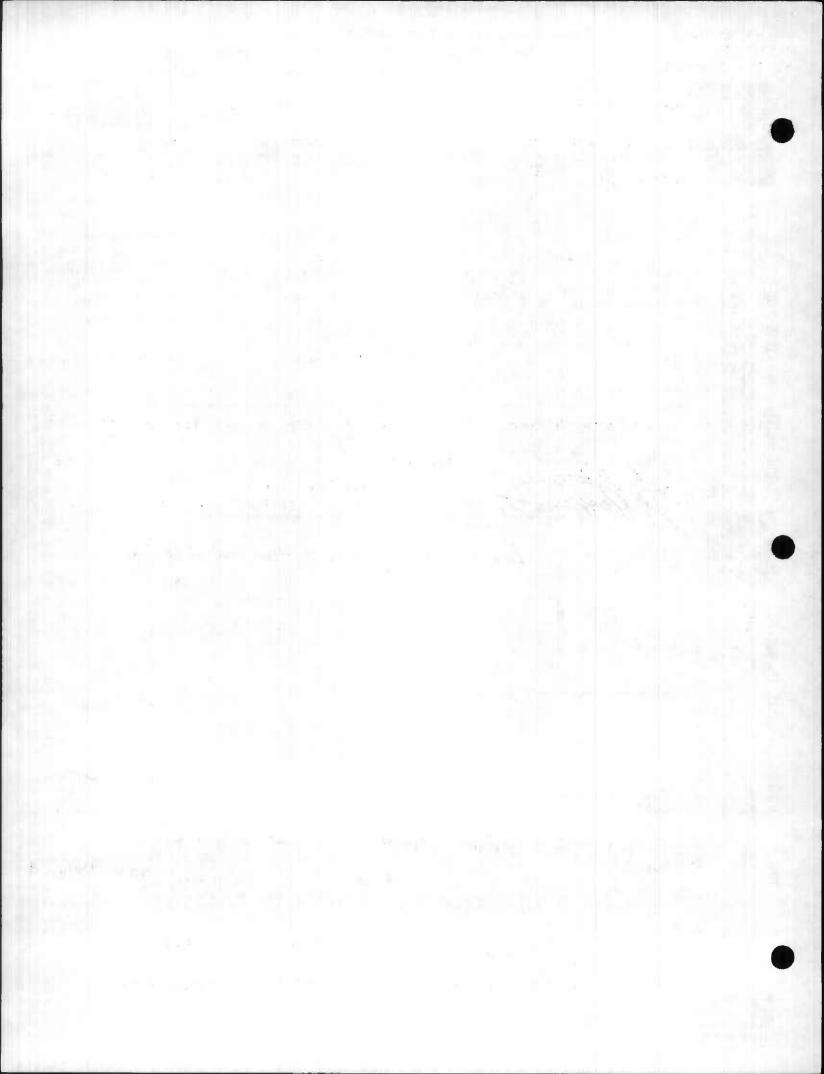
29a. Certifier (Check only one)

4 Momicide

MAR 1 9 1999

5 Pending





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month Yaar **Physician** 1349 m HARDIN MARCH ASZLEE 1999 13 /Medical 4b. City, Town, or Location of Death 4e Facility Nema (If not institution, giva street and number) 4c. County of Death Examiner CHURCH BALTIMORE HOSPITAL HOME 7. Aga (In yrs. last birthday) If Undar 1 Yaer If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country)
 SC Fui eral Months Days Min. 10 M 20 F Hours 21242 7516 Director 11-12-27 Usuel Residence of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore NA MD 1 Yas 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 526 N. Linwood Avenue USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-iff Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Wes Decedent Evar in U,S. Armed Forcas? 14. Race - Amarican Indian, 11 Merital Status Black, Whita, etc. 1 ☐ Yas 2 X No If Yes, Giva 1 Never Merried 2 Married 1 ☐ Yas 2 No Specify: Specify: Black P 3 ₩ Widowed 4 Divorced Yeer or Dates: 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) 8th Grade Coilege (1-4or 5+) in Home Housewife 17. Fethar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be Nancy Johnson Hall George 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 526 North Linwood Baltimore, Maryland 21205 Important: If Item 27 is any injury or other Howell Elnora altimore, 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition Pages 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Western Star Cemetery 03-17-99 Baltimore, MD 4 Donthion 5 Other (Specify) 21. Sign of Funeral Service 22. Nama and Addrass of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue death. Do not antar the mode of dying, such as cardiac or respiretory errest, Approximeta Intervat Batween Onset and Death **Physician** Immediata Causa (Final disaase or condition rasulting in death) /Medical SEPTIC DAY SHOCK Examiner Due to (or es a consequance of): Examiner DAY ACIDOSUS METABOLIC attending physician and for use as the burial-transit that the death certificate be axecuted Sequentially list conditions, if any, taading to immadiete causa. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medicai Due to (or es e consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☑ Unknown 3 1 Yes 2 No signed t PIVERTI CULOSIS Records, by 24b. Wara autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? page 2 1 Yas 2 No 1 ☐ Yas 2DINO certificate Division of Vital after death.

Director: After this certifica 25. Was case refarred to medicat Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To 28a. Data of Injury (Month, Day Year) 27. Manner of Deeth 28d. Dascribe how Injury occurred 28b. Tima of 28c. tnjury et Work? 5 Pending invastigation 1 ANatural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) in by 4 Homicide To the Hospital or lithin 24 hours aft to the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, daath occurred at tha tima, deta and place, and due to the cause(s) and mennar as steted.

2 Medical Examiner: On the basis of examinetion and/or invastigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. edicai 29a. Certifier (Check only one) 29b. Signature and title of certified 29c. License number 29d. Data signed (Month, Day, Year) 3-13-99 D39629 30. Nama and address of person who completed causa of death (Itam 23a) (Type, Print) 21231 CHURCH MD ALEXANDER SY MD 1 tOSPITAL BAUT HOME 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 9 1999 Registrar

Printer ROTH OF SELECTIVE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 99ear 17 Pay Wanda Elizabeth Holley 6:58am Mar. 4h City Town or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Deeth 2109 Barclay Street Baltimore If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) Days Hours 1□ M 2 0 F Yrs 212-88-4567 35 MD Usual Residence of Decedent 10e. State 10c. City, Town or Location 10d. Inside City Limits 10b. County to Yes 2 □ No Baltimore MD 10e, Street and Number 10f. Zip Code 10a. Citizen of Whet Country? USA 2109 Barclay Street 21218 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Maritai Status Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes X No If Yes, Give Yeer or Detes: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) High Sch. Grad Unemployed Never-worked NA 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Bradley Selestus Holley Susie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2109 Barclay Street Baltimore, MD. 21218 Susie Holley 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ₩ Burial 2 Cremetion 3 Removal from State Voshell Mem. Gardens 03-22-99 Dundalk, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Euneral Service Licenses 22. Name end Address of Fecility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 240 plications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, one cause on each line) 23a, Part 1. Enter the diseas val Bet Immediate Ceuse (Final disease or condition resulting in death) BREAST CANCER METASTATIC Due to (or as a consequenca of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or itema 23a or 28a-f ahow the Med cal Examiner must be notified at

natural', or

death

filed within 72 hours effer

Hygiene.

permit. Pages 1 and 2 should be filed will be be before the bygien. Inportant: If item 27 is marked other that any injury or other traumatic event, I'm and

Directo

Funeral

by

Completed

Physician/Medical Examiner 88 PV Completed Be

ettending physician and for use as the buriel-transit the signed by t peen certificate 2 this uneral Certification: After

the death certificate be executed Box 68760 P.O. The law requires that hes . Physician: Attending ò

Division of Vital Records, efter death.

Director: Aft
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Registra

resulting in death) Last Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Wera autopsy findings available prior to completion of ceuse of death? 24e. Wes en autopsy 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation Naturel 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or hypostigation, in my opinion, death occurred at the time, date end placa, end due to the ceuse(s) and manner states. 29a. Certifier

29b. Signature and title of

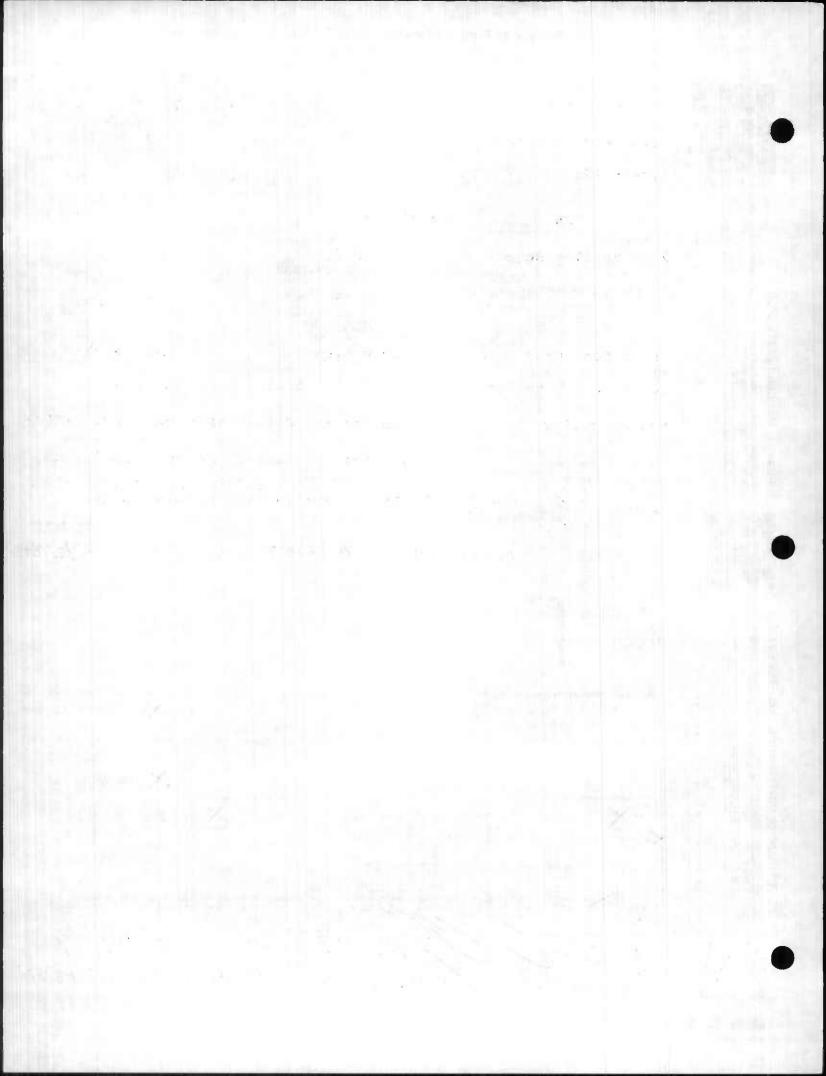
30. Neme end edd m 23a) (Type, Print) ANTONIO WOLFF

MO - JOHNS HOPKINS HOSP

31. Date filed (Month, Day, Yeer) MAR 1 9 1999

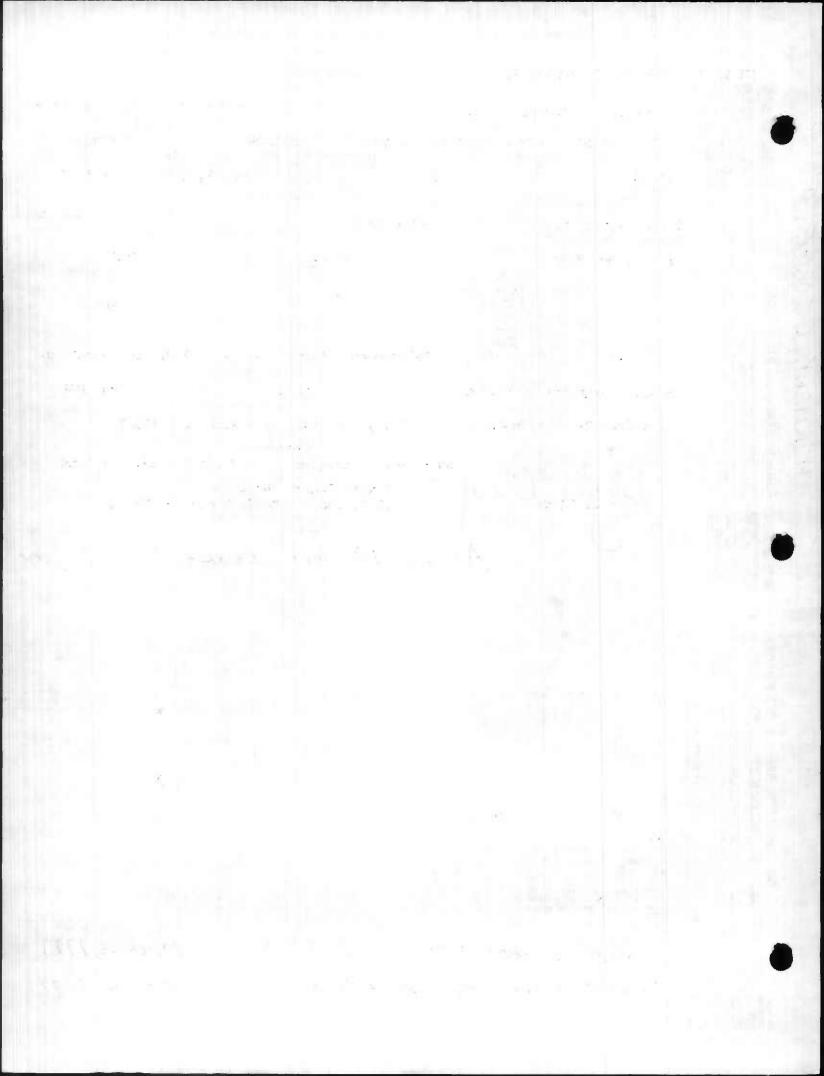
(Check only one)

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible.

			WR.			rtificate of	Doan			Reg. No.			
	1. Decedent's Name (First, Mi	iddle, Last)						2.	Date of Dea	ath Day	Year	3. Time of	
nysician Medical	George	Josei	ph	Herman	n			M		16, 19	-	6:25	
kaminer	4a Facility Name (If not institu	tion, give s	treet and n	umber)			4b. City, To	own, or Locat	ion of Death	4c. County	of Death		
	GREATER BA	LTIM	ORE	MEDICA	L CEN	TER	TO	WSON		BAL	TIMO	RE	
neral	5. Social Security Number	6. Sex		7. Age (In yrs.	. last birthday)	Months Days		Min. 8.	Date of Birt (Month, Day	MAY 8	9. Birth	place (State or	
ector	214-24-8365	1 🗶	M 2□ F	7	O Yrs.	Working Days	riodis		ay 7,			yland	
	Usual Residence of Decedent			140.0					10d. Inside Cit				
1	10a. State 10b. Cou	nty		10c. C	ity, Town or Le	ocation							
be notified Director	Pennsylvania	York			Glen							1 🗆 Yes	
Dire	10e. Street and Number					10f. Zip Code				10g. Citizen of	n of What Country?		
Tan Tan	R.R.2, Box 2	408				1732					USA		
edical Evantinar must be notified at sleeted by Funeral Director	11. Marital Status	1	Was Dec Armed F	cedent Ever in U Forces?	J,S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Or pan, Mexica	rigin? (Specif in, Puerto Ric	ncity Yes or No- Rican, etc.) 14. Race - American In Black, White, etc.				
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	17. Father's Name (First, Middle, Last)							ers Neme (F			ne)		
To	George Augus	Mari		C.			- KARN						
E T	19a. Informant's Name/Relation				19b. Maili	ing Address (Stree	t and Numb	per or Rural R	loute Numbe	or, City or Town	, State, Zij	p Code)	
th Ter th	Helen June He	rmann	/Husb			.2, Box 2	2408,	-					
r othe	20a. Method of Disposition 1 Burial 2 Crematic	2 🗆	om aval fram		Place of Dispo cemetery, cre	osition (Name of matory or other pla	ace Cren	natory	Dete	20c. Location	- City or T	own, State	
Iry or	4 Donation 5 Other		enioval from	Juliano		e-Washing			17/99	Laurel.	Mar	vland	
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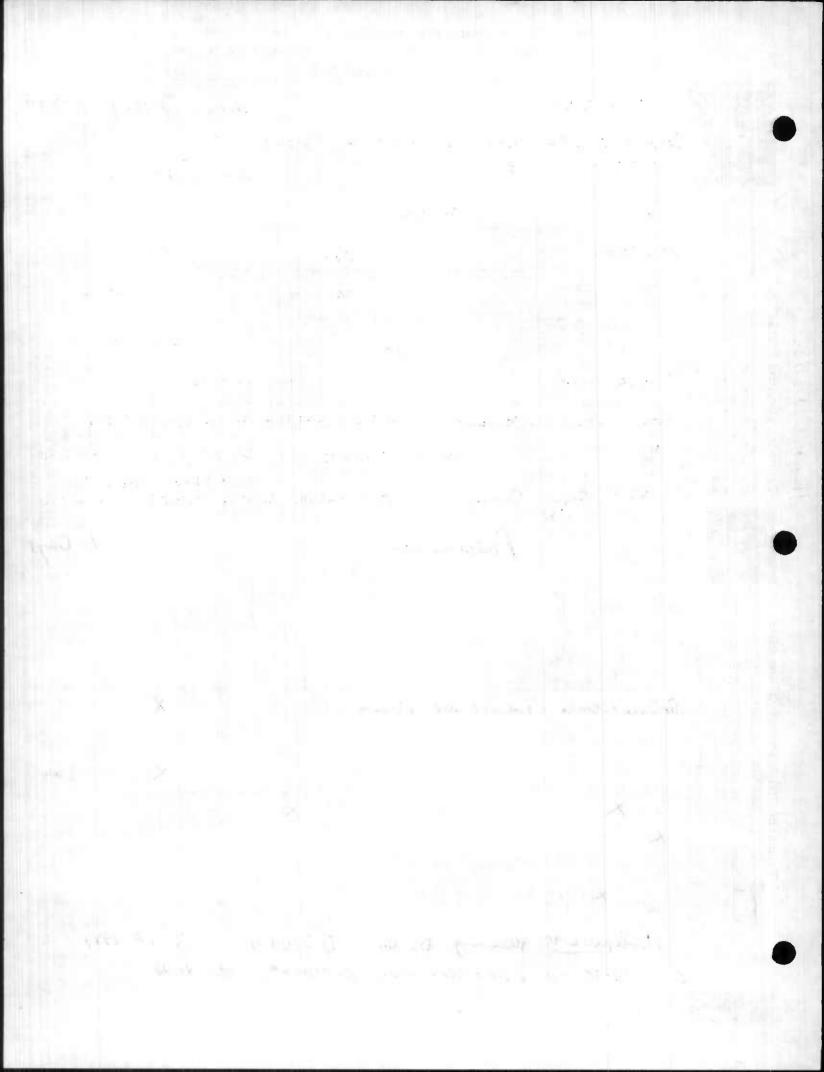
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State	31. Dete fited (Month, Dey	Yeer)	32 Regi	strer's Signat	ure							

State Registrar

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32 Registrer's Signature

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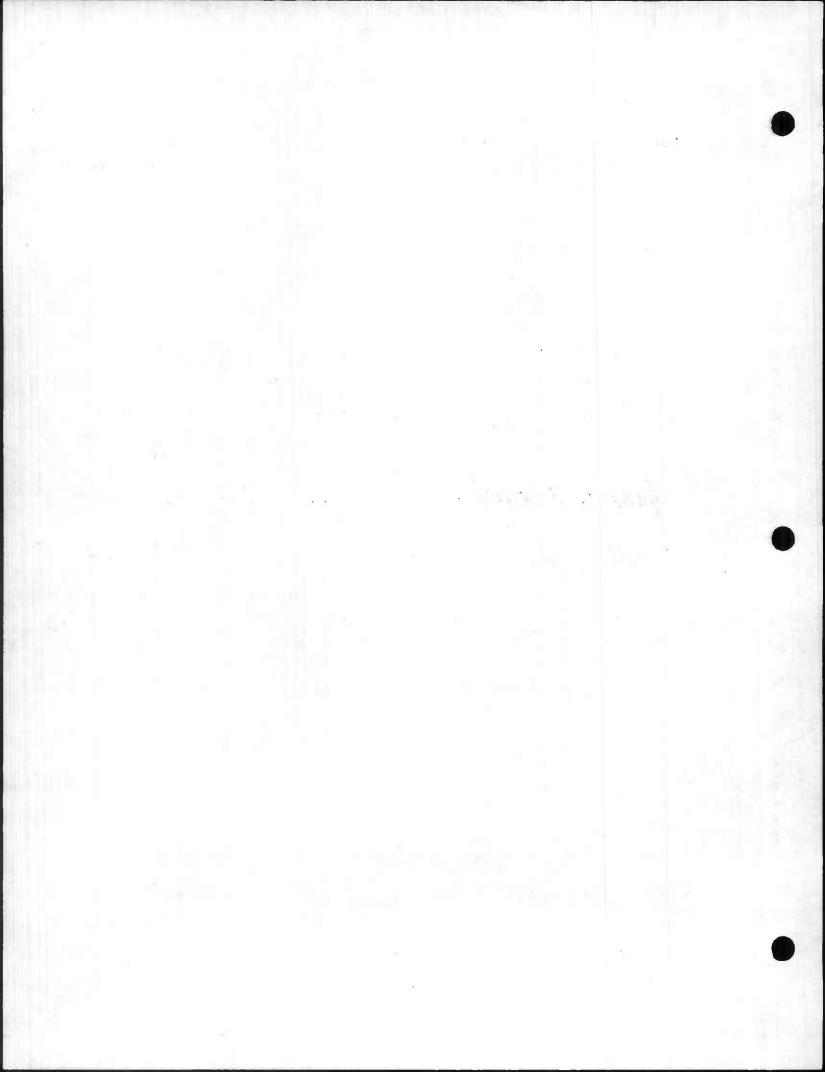
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev Yeer Physician Margaret M. Hales 9 1999 11:00 P.M. March /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Crofton Crofton Convalescent Center 8. Dete of Birth (Month Day Sear) 1914 Birthplace (State or Foreign Country) Washington D.C If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□ M X2K F 84 577 09 5318 Yrs. Director Usual Residence of Decedent with the Manyland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Weston Examiner must be notified at 1 ☐ Yes 2KNO Director Prince George's Upper Marlboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 16018 Marlboro Pike 20773 United States death Funeral Wes Decedent Ever in U,S. Armed Forces?

1 Yes 22No If Yes, Give Year or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Meritel Status filed within 72 hours after 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes ZXNo Specify: Specify: g 3 ☐ Widowed 4 ☒ Rivorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien Important: If Item 27 is marked other than any Injury or other treumetic Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be George Menke Christina Nolte 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 16018 Marlboro Pike Box 403 Upper Marlboro MD 20773 Daughter Nancy H. Hill 20b. Place of Disposition (Name of cametery, cremetery, cremetery, cremetery, cremetery or other place) March 13 Detel 1999 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Washington D.C. 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Cemetery

22. Name and Address of Facility
Robert E. Evans Funeral Home, Inc. 21. Signeture of Funerel Service Licensee 16000 Annapolis Rd. Bowie Maryland 20715 23a. Port. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Preumoria 2 weeks disease or condition resulting in death) **Examiner** Due to (or as e consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or es e consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 3 1 Yes 20 No 3 Probably 4 ☐ Unknown Hypertension signed be det Records, p 24b. Were autopsy findings evaileble prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed page 2 a 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funaral director, Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Menner of Death 28a. Dete of tnjury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28e. Plece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 16 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. 29e. Certifier (Check only one) 2 Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end pieca, end due to the ceuse(s) end manner steted. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certified D 56343 MP March 10, 1999 un 30. Name end address of person who completed cause of death (ftem 23a) (Type, Print) Suite Ato Bowie, Maryland 20715 Kelvin Hao 3231 Superra Lave 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar MAR 1 9 1999



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 1999 16 12:12 AM Mildred Margaret Rixse Hann /Medical 4e Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 406 Carvel Beach Rd. Baltimore If Under 24 Hrs. If Under 1 Year 8. Date of Birth Month, Day, Year June 11 1943 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X F Months Hours Maryland 219-38-3623 55 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or hems 23s or 28s-1 show the Medical Examiner must be notified at 1 Yas 2 No Director Maryland Anne Arundel Baltimore 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 21226 USA Funeral 406 Carvel Beach Road 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Meritet Stetus permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or her important: if Item 27 is marked other than "natural", or her any Injury or other traumadic event, are Medical Examines pages. 1 Never Married 2 Merried Specify: White altimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner Lounge/Tavern 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rixse Amos George Vera Caroline Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Hann - Spouse 406 Carvel Beach Road, Baltimore, MD 21226 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Cemetery !March 18 Howard Co., Maryland 21. Signature of Funeral Service Licensei 22. Name and Address of Facility Stallings Funeal Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Pert l. Enter the disease, or complications that caused the shock, or heart tailure. List only one cause on each line. Approximete Interval Between Onset end Deeth Do not enter the mode of dying, such as cardiac or respiratory errest, **Physician** Small cell lung /Medical Immediate Cause (Final cancer disease or condition resulting in death) Examiner Due to (or as a consequence of Examiner attending physician and for use as the burial-transit The lew requires that the death certificate be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t Records. þ ate has been sig 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was en eutopsy 1 Yes 2 No 1 Yes 2 No Division of Vital or Attending Physician: 25. Was casa referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menngrof Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident after deat Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) taly filled in by 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29b. Signature and tale of contrib 29c. License number 29d. Date signed (Month, Day, Year) 199 D45880 16 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Leon Hwang, MD 10400 Connecticut Ave., #606, Kensington, MD 20895 31. Date filed (Month, Day, Year) 32. Registrar's Signature

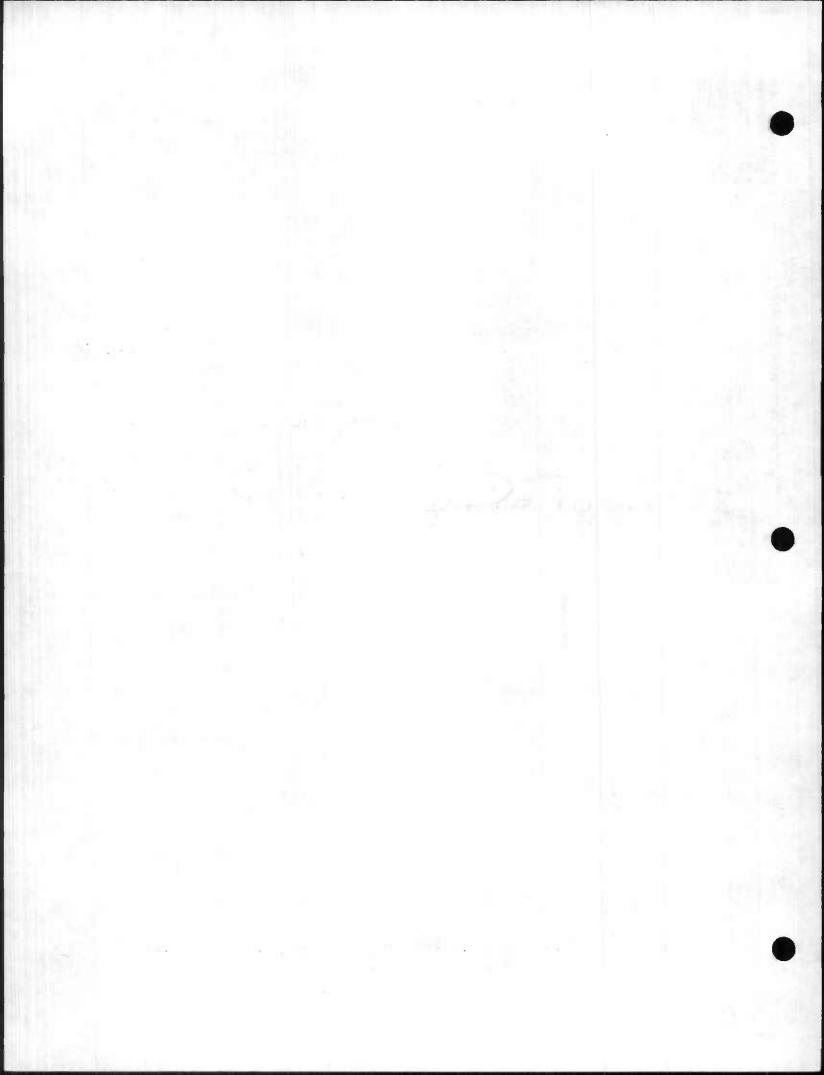
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Sports



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Item: 5 per F.H 3/17/99 reb State of Maryland / Department of Health and Mental Hygiene Item: 1 per MEO G-769 3/17/99 reb Certificate of Death 1. Decedent's Neme (First, Middle, Last) [A.K.A SOPHIA M.] 2. Dete of Deeth 3. Time of Deeth **Physician** Month WILKENS MAR 3 0 /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** pital Burnie 405 (olen rundel 5. Sociel Security Number 9724 If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Pay. 7. Age (In yrs. last birthday) If Under 1 Yeer 6. Sex Birthplace (State or Foreign Country) **Funeral** Deys 100 M 2□ F 212 46 2946 52 Director Maryland Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show Maryland Anne Arundel Pasadena 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a 7961 E. Shore Rd. 21122 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1X Navar Married 2 Merried "natural", or 1 Yes 2 No Specify: White Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry se filed within 7 al Hygiena. Elementary/Secondery (0-12) Collaga (1-4or 5+) Self-Employed / Domestic House Keeping 11 permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If Nem 27 is marked other
any injury or other traumatic avents. 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Clifton Wilkens Helen Woolwine 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Stella Knighton / Sister 7961 E. Shore Rd., Pasadena, MD 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Remove from State 3/6/99 Green Mount Crematory Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility CAFA Stephen D. Lohrmann P.A. Olleman 8717 Green Pastures Dr., Baltimore, MD 21286 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on each line. Approximeta Intervel Between Onset end Deeth **Physician** /Medicai Immediate Cause (Final disease or condition rasulting in death) ENSUSFICIENCY Examiner riosclorotic Sequentielly list conditions, if eny, leeding to Immadiate cause. Entar Underlying Couse (Diseesa or injury that initieted events rasulting In deeth) Lest Due to (or es e consequenca of) Physician/Medical Due to (or es e consequenca of): use Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24a. Was an eutopsy performed? 24b. Wera autopsy findings eveileble prior to completion of cause of daath? Completed 1 Yas 2 No 1 ☐ Yaa 2 ☐ No 25. Was case rafarrad to madical Be 26. Place of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28a. Data of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident

and physician s the burial Box 68760 P.O. signed by t Records. peen cartificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completaly filled in by the funeral director,

the

Baltimore, Maryland 21215-0020

Certification:

edicai

3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. 29a. Certifier

29b. Signeture end title of cartifier

06054

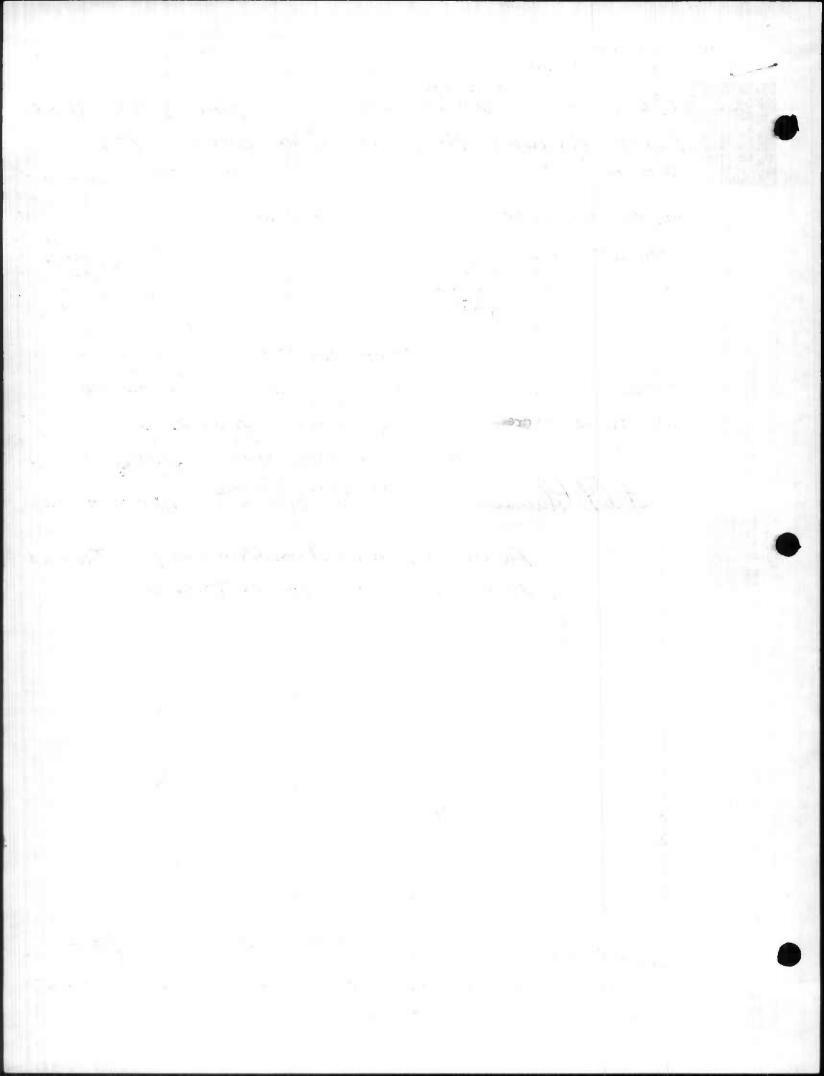
29d. Dete signed (Month, Dey, Year)

30. Name end eddress of person who complated causa of death (Item 23e) (Type, Print)

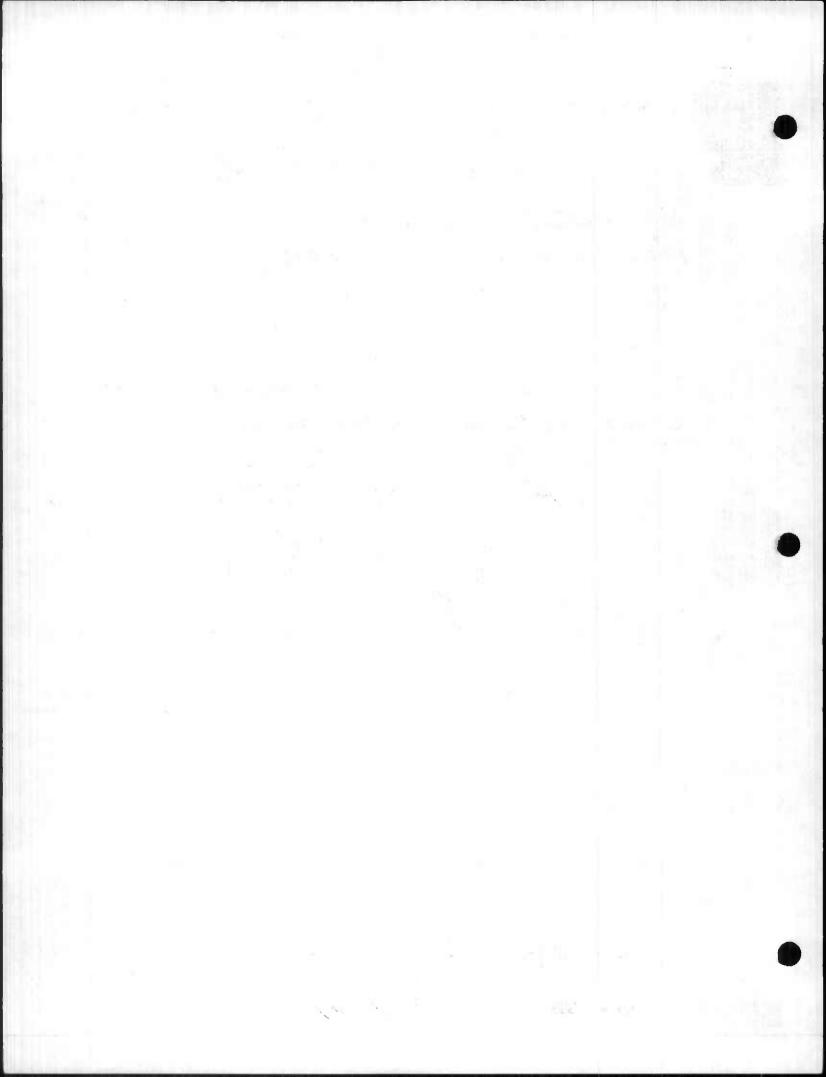
5 America DNES

31. Date filed (Month, Day, Year) 32. Registrer's Signature MAR 17 1999

State Registrar



ITEM	1: 1	1 PER MD G769 3-19-99			ent of Health and ate of Death	Mental Hygie	00	08953
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Examin Funeral Director		71/ 70 7/00	an Hospita	last birthdey) If Uni Yrs.	BAHING der 1 Yeer If Under 24 Hr	s. 8. Date of Birth	4c. County of De	irthplece (State or For
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s efter dea	by Funeral	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Veer or Detes:		cedent of Hispenic Orlgin? (pecify Cuben, Mexican, Pue	Specify Yes or No- irto Rican, etc.)	14. Race - An Bleck, Wh Specify:	nerican Indien, lite, etc.
within and then then	Completed	15. Decedent's Edu (Specify only highest grad Elementery/Secondary (0-12)	cation e com <i>pleted)</i> College (1-4or 5+)	16a. Decedent's U (Give kind of life. DO NOT	work done during most of w Tuse retired)	orking 161	b. Kind of Busines	s/Industry
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gas 1 and 2: It of Haalth ar If Item 27 is or other trau		19e. Informent's Name/Reletionship (7) CROSBY 5: Ha 20e. Method of Disposition 1 Buriai 2 Cremation 3 F	WKINS-SON Remove from State	Plece of Disposition (formetery, cremetory)	or other place)	21239 Dete 200	c. Location - City o	or Town, Stete
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l di	ဥ	1 Yes 2 Ne 1 Yes 2 Ne 1 Yes 2 Ne 1	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury M	DOA Other: 4 Nursing 28c. Injury et Work? 1 Yes 2 No	Home 5 Residence 28d. Describe how		ecify)
24 hours effer de Funeral Directo	I Certification:	3 Suicide 4 Homicide 6 Could not be determined	City or Town, S	itete)	Rurel Route Number,			
within 24 hc	Medical	one) 2 Medical Exami	elclen: To the best of my kno ner: On the besis of examine end menner stated.	tion end/or investigati	on, in my opinion, deeth occ	curred et the time, dete	end plece, end di	ue to the ceuse(s)
To To Con	×	29b. Signeture end title of certifier	B. 10	2	19c. License number	29d.	Dete signed (Mod	1th, Day, Year)
0		30. Name and address of person who co	5601	Loch K	Paven Blr	d, Bal	times.	ND 2123
Stat Registra	_	31. Dete filed Month, Day, Year 1999	32 Registrer's Signe	Sture &	ach!			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month 12:35 FM ALEXANDER G. HOWARD 10, MARCH 1999 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) JOHNS HOPKINS BAYVIEW BALTIMORE 7. Aga (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7 1 Yrs. Months Deys Hours Min. 5/26/26 9. Birthplace (State or Foraign Country) CHINA 5. Social Security Number 18 M 20 F 327-24-1380 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stata 10b. County 1 ☐ Yes 2 No DUNDALK BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21222 U.S.A. 1605 RITA ROAD 12. Was Decedent Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - Amarican Indian, Bleck, White, etc. 11. Marital Status 1 ☐ Nevar Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highast grade complated) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) MACHINIST BETH STEEL 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) NADIA GURSKY ELBERT CLYDE HOWARD 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1605 RITA ROAD BALTIMORE, MD. 21222 MRS. CARMELLA HOWARD 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 18 Buriai 2 ☐ Cramation 3 ☐ Removal from State ANDREW, S CEMETERY3/15/99 DUNDALK, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses KACZOROWSKI FUNERAL HOMEP.A. 23a. Pert1. Entar the disease, or comp cetions that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart fellure. List only one cause on each line. 21222 Approximete Intervel Between Onset end Deeth ACCUTE MYOCARDIAL INFARCTION Immediate Cause (Final disease or condition resulting in deeth) 2-3 HOURS Due to (or es e consequence of): ATTEROSCIEROTIC CARDIOVASCULAR DISERSE Sequentially list conditions, if eny, leading to immediate cause. Enter Undarlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. DIABETES MELLITUS, TYPE 2 1 | Yes 2 No 3 | Probably 4 | Unknown HYPERLIPIDEMIA 24b. Were eutopsy findings evaileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? COPD & ASBESTOS LUNG DISEASE 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 28b. Time of 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide

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Physician

' /Medical

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

should be f and Mental H marked of

permit. Pages 1 and 2 Department of Heelth e Important: If Nem 27 is

Physician

/Medical

Examiner

Physician/Medical

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Division of Vital Records, P.O. aftar death.

Director: After din by the fun 8 Hospital of 24 hours all Puneral D

To the F within 24 Registrar

29a, Certifier (Check only

WISE 31. Date filed (Month, Dey, Year) MAR 1 9 1999

marian

30 Name and address of person who completed cause of death (Item 23e) (Type, Print)

29b. Signeyere and little of certifier

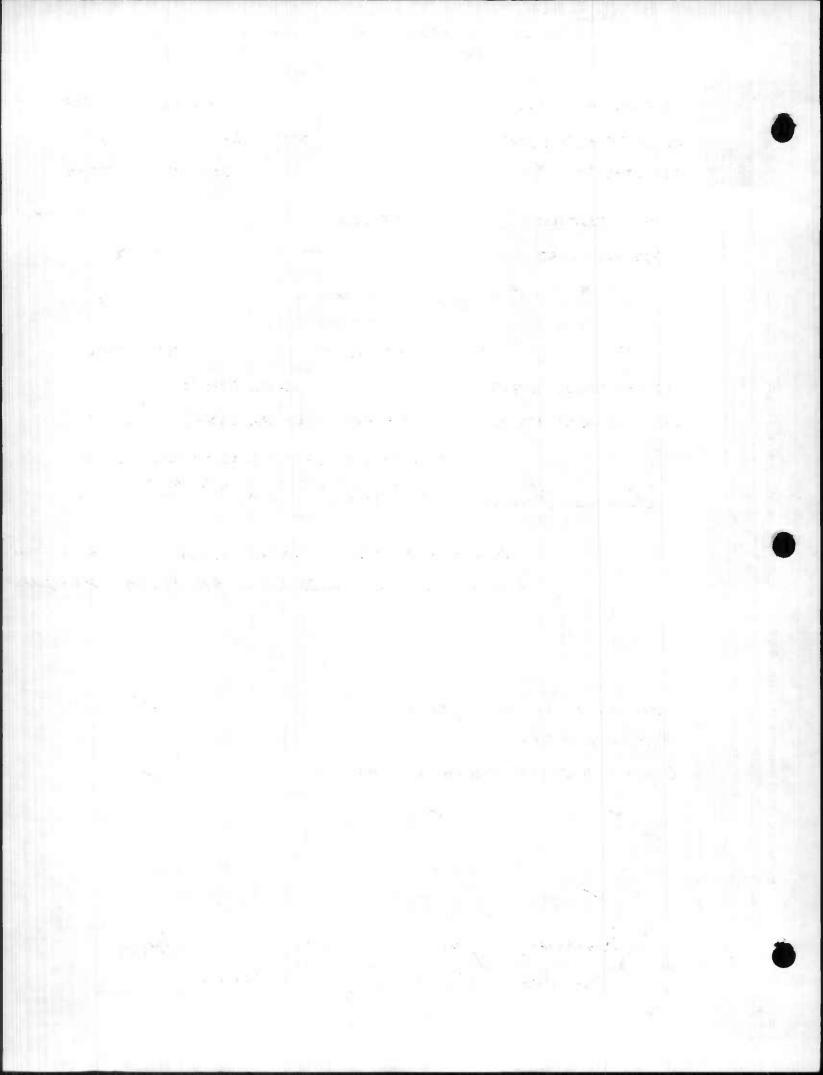
BALTIMORE 32. Registrer's Signature

1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es stated.

2 Madical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and place, end due to tha cause(s) and mannar stated.

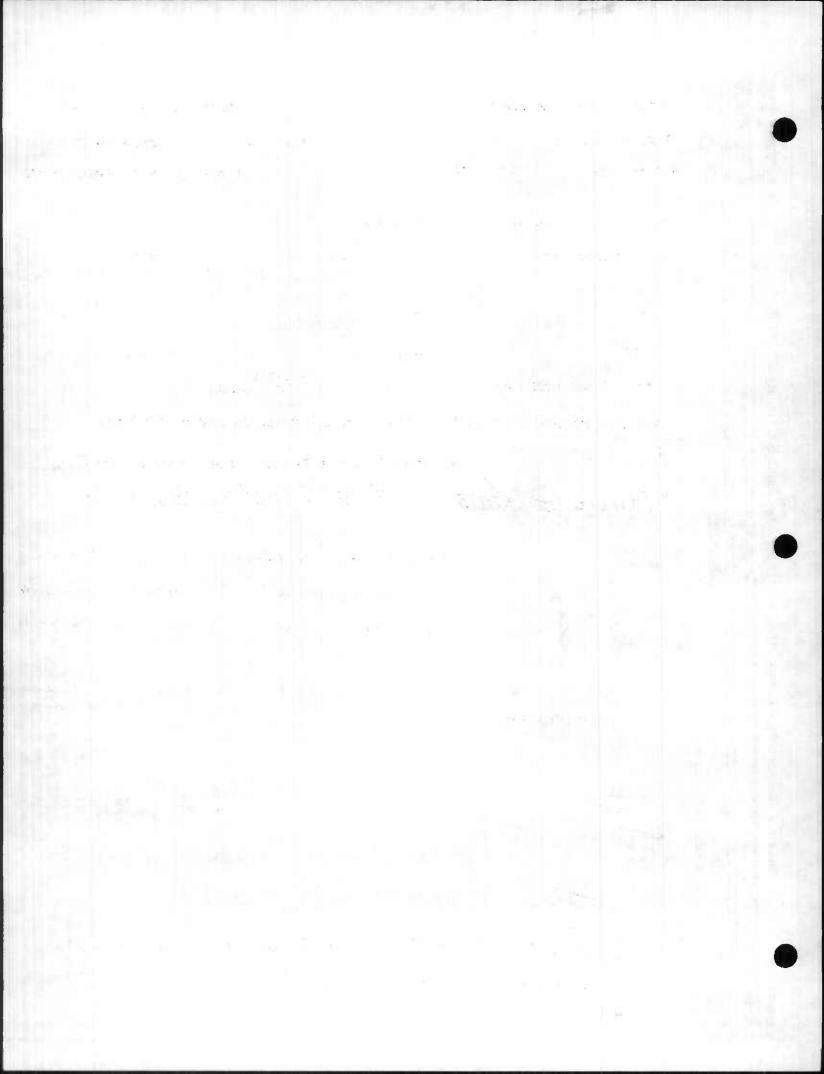
29ç. License number

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Certifica	te of	Death	1	Reg. No.						
Physician	1. Decedent's Name (First, Middle,						2. Date of D Month	Dey	3. Tima of Deeth					
/Medical	Carolyn Louise		_	16, 1999 th 4c. County o	0808									
Examiner	4e Fecility Neme (If not institution,					4b. City, Town, or								
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e Ma	MD Anne A	rundel	Edg	ewater					1 ☐ Yes 2 No					
or 2	10e. Street and Number			10f. Z	ip Code			10g. Citizen of Wi	het Country?					
23a	1623 Marlboro				2103			USA						
gas 1 and 2 should be filed within 72 hours aftar death with the Maryland if of Haalih and Mental Hygiana. If item 27 is marked other than "natural", or thams 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 X Widowed 4 Divorced	12. Was Decedent E Armed Forces? d Yes 277 If Yes, Give Year or Dates:		13. Was Decentif Yes, sp	7.7	dispanic Origin? (S an, Maxican, Puer Specify:	Specify Yes or N to Rican, atc.)	o- 14. Hace Bleck Specify:	- American Indian, , Whita, etc. White					
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filed with Hygiana. Hygiana.	17. Fether's Neme (First, Middle, La	ast)	110	iliciliaisc.		18. Mother's Na	me (First, Middle	e, Maiden Sumeme						
Mental H Mental H mrked off	James Malcolm I	Holloway				Olive	s Barber							
d 2 should be filed within 72 hours aft the and Mental Hygiene. 7 is marked other than "natural", or traumatic event, the Medical Exert To Be Completed by F	19e. Informent's Name/Reletionshi	p (Type, Print)	19b.	Mailing Addres	ss (Street			ber, City or Town, S	Stete, Zip Code)					
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oemit. Pagas 1 and 2 Department of Haalth mportant: If Item 27 I any Injury or other tru bnce.	20a. Method of Disposition		20b. Place of	Disposition (No.	eme of		Dete	1	City or Town, Stete					
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permit. Pa Departmar Important: any Injury ance.	21. Signeture of Funeral Service Li		Lakelio			ss of Fecility	03/20	_Davidsor	nville, MD					
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Physician	shock, or heert failure. List o	nly one cause on each lin	9.						Intervel Between Onset and Death					
/Medical	Immediate Ceuse (Finel		No.					. 3	1 13					
Examiner	disease or condition resulting in death)	a			WEA	ECTIO		1 Hour						
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axec an an rial-tr	Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events								>loyear					
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Physician: this carificatal director.	examiner?	Hospital: 1 ☐ Inpatier	nt 2 ER/Out	patient 3 [DOA Ot	her: 4 Nursing	Home 5 -Re	sidence 6 □Othe	r (Specify)					
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g Ph arthi				M		Yes 2 □ No								
ath. r: Attar thi na funaral	2 Accident investiga		28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month HEISS DANIEL JR. LAYMOND 208 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Carroll Carroll County General Hospital Westminster 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Undar 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Year) Birthplaca (State or Foreign Country) 215-32-4663 ₹ M 2 F Freeland 1933 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No Baltimore Upperco Md. 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21155 U.S.A. 16746 Ridge Road 12. Was Decedent Evar in U,S. Armed Forces?

1 Yes 2 No If Yes, Give 1953-55 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Maxican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 11. Marital Status 1 Naver Married 2 Married 1 Yas 2 No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) Collega (1-4or 5+) Greenhouse 12 Florist 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Sumeme) Raymond Daniel Heiss Sr. Elnora Lloyd 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) 16746 Ridge Rd. Kathleen Ann Heiss - wife Upperco, Md. 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Ramoval from State Hampstead Cemetery March 19, 1999 Hampstead, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Eckhardt Funeral Chapel 21. Signature of Funeral Service Licensee 3296 Charmil Dr. Md. 21102 Manchester, 23a. P.m.f. Enter tha disease, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL INFARCTION disease or condition resulting In death) CHRONIC ISCHOULL FEART DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ASCUI 24b. Were autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? 2 No 1 Yas 2 No 1 Yes 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residenca 6 Other (Specify) 1 Yes 2 No 28e. Dete of Injury (Month, Day Year) 27. Menmer of Death 28d. Dascribe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Placa of thjury - At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

physician end s the burial-transit Records, P.O. Box 68760 88 signed t

Physician /Medical

Examiner

Physician

/Medical

Examiner

Director

Funeral

Aq

Completed

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at

the Maryland

death

permit. Peges 1 and 2 should be liled within 72 hours after deal Department of Health and Mentel Hygiena. Important: If item 27 is marked other than "netural". or item any injury or other traumetic event.

Examiner Physician/Medical þ Completed Be 0 Certification:

Medical

4 I Homicide

29a. Certifier (Check only one)

this funerel After i or Attending after death. Director: Aft

Division of Vital A 24 hour. To the Within 2

State Registrar 29b. Signature and title of certifier

29c. Licensa number 5079

1 Cartifying Physictan: To the best of my knowledge, death occurred et the time, dete end pleca, and due to the ceuse(s) end menner es stated.

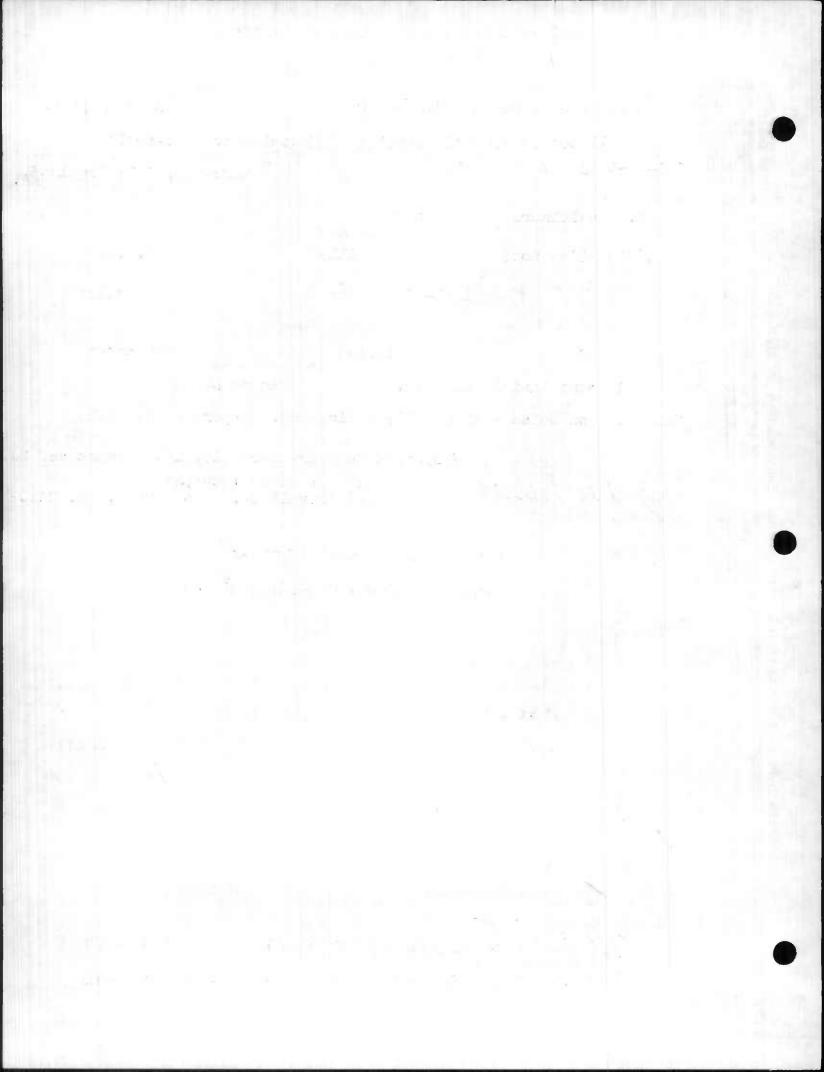
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) .16,99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

CARROLL C00 W 54 HOSPITAL

WESTHINSTER MA

32. Registrar's Signature 31. Data filed (Month, Day, Year) MAR 19 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Hylton LYIS MAR 1010AM 13 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Nyrsing Home Columbia Howard Orien 7. Aga (In yrs. last birthday) If Under 24 Hrs. If Under 1 Year 8. Data of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) Days Months Hours 1□M 20 F Yrs. 92 076-44-9063 October 9, 1906 Jamaica Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Maryland Howard Columbia 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21045 9395 Indian Camp Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forcas? 14. Race - American Indian, Black, Whita, atc. 1 Tas 2 No If Yas, Give Yaar or Datas: 1 Nevar Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home 8 Housekeeper 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) (unknown) George Hylton 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9395 Indian Camp Road Columbia, Maryland 21045 Grandchild Jeptha Allen 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Removal from State 4 Donation 5 Othar (Specify) 03/23/99 Hastings on Hudson, New York Mt. Hope Cemetery of Funaral Sarvice License 22. Name and Address of Facility Lee O. Wood Funeral Home 1200001 23 East 2nd Street Mount Vernon, NY 10550 Part 1. Entar the disease or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximata Intarval Between Onset and Death Immediata Causa (Final disaasa or condition rasulting in death) Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaase or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 23b. Did tobacco use contribute to the cause of death? Fibrillation 3 Probably 4 Unknown 1 Yes 2 No Inutrition 24b. Wera autopsy tindings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yas 2 X No 1 ☐ Yas 2 No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Homa 5 Rasidence 6 Other (Specify) 27. Manner of Death 28c. Injury at Work? 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accidant 5 Panding 1 ☐ Yes 2 ☐ No

attending physicien and for use as the burial-transit Division of Vital Records, P.O. Box 68760, signed by t certificate or Attending Physician:

Examiner Physician/Medical by Be Completed Medical Certification: To this After this funaral of death. Director: / hin 24 hours after of the Funeral Direct uplately filled in by

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Director

Funeral

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Completed

Be

death with the Maryland

filed within 72 hours after

Hygiens.

permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy important: If them 27 is marked ofthe ey injury or other treumatic event, pines.

Physician /Medical

Examiner

Baitimore, Maryland 21215-0020

25. Was casa ralarred to medical 1 Yes 2 No

> invastigation 6 Could not be detarmined

28a. Place of Injury - At homa, larm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatura and titla ol certifian

3 Suicide

29a. Cartifian

4 Homicida

29c. License number D0052940

29d. Data signed (Month, Day, Year) MAR 13

.Shear 30. Nama and address of person who complated causa of death (Item 23a) (Type, Print)

Ridge SHAH, MOIOSOS HICKORY

31. Data liled (Month, Day, Year)

1 8 1999

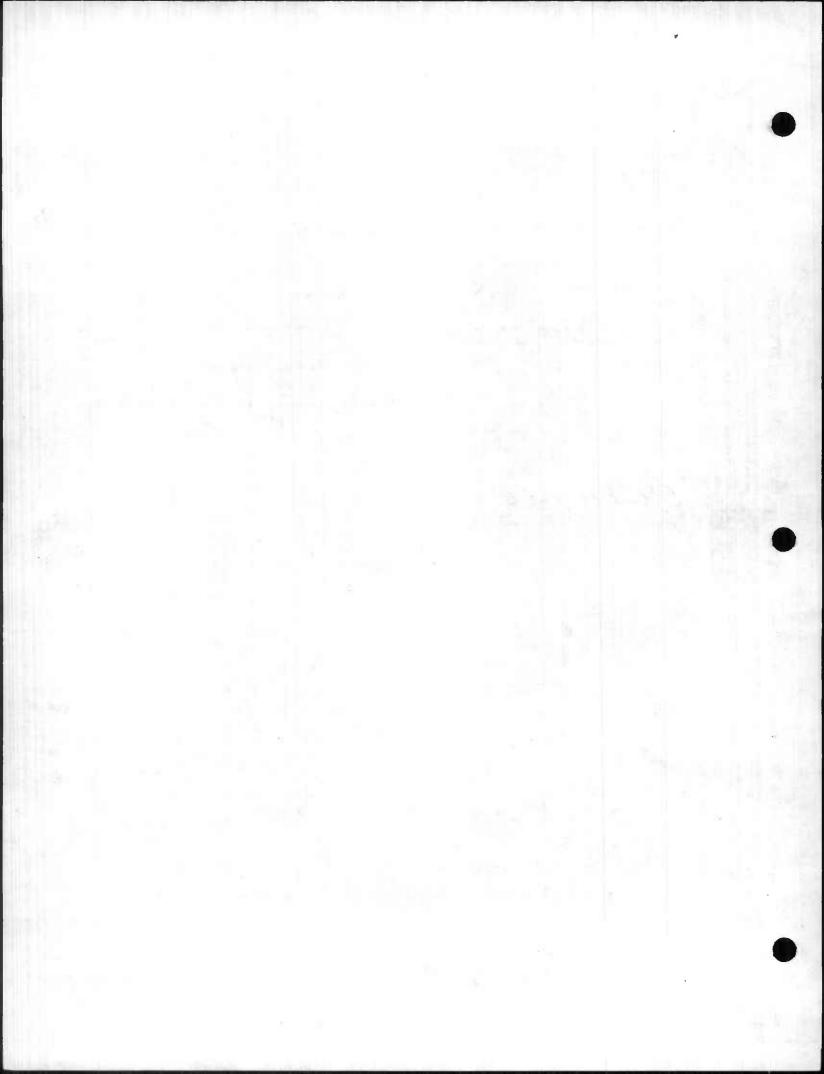
32. Registrar's Signatura Denest.

MD

Rd #210, Columbia, MD 21044

State Registrar

To the Within 2



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ITEM: #7 PER F.H. G769 3-19-99 WR 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month **Physician** Madeline . E. 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE ST ELIZABETH'S 3320 BALTIMURE Banson AV 7. Aga (In yrs. last birthday) AVE If Under 24 Hrs. If Under 1 Year Months Days 5. Social Sacurity Number 8. Date of Birth (Month, Day, Year) 1 M 2 F **Funeral** 88 Hours 217-34-9155 02/26/10 Director Usual Residence of Decedent 10b County 10c. City, Town or Location NA BALTIMOre Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Charles 21218 U.SA 3900 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ZNO If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puarto Rican, etc.) Race - Amarican Indian, Black, White, etc. 11 Marital Status 1 Nevar Married 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 BUSINEGS DINNER 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Combs 2 ames HNNIE M. Combs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Fred Grant 1000 Cotheral Street BATIMON, MD. 21201 - Guardian altimore, 20b. Placa of Disposition (Name of cematery, crematory or other place) 20a. Mathod of Disposition 1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State 3-20-99 BANimone, MD 4 ☐ Donation 5 ☐ Other (Specify) Kedeemer 21. Signature of Funeral Service Licensee Albert P. WYLie 7/H PA 22. Name and Address of Facility 638 N. Gilnor St BATTIMONE, MO. 21217 23a. Part 1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

Physician /Medical Examiner

Physician/Medical Be edical Certification: To

Completed

Affer s after death.

Hospital or Attending Physician: The law requires that the death certificate be exec P.O. Box 68760. Division of Vital Records.

To the Hospital e within 24 hours a To the Funeral D State Registrar

25. Was case referred to medical axaminar?

Immediate Cause (Final

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

disease or condition resulting in death)

1 Yes 2 No 27. Manner of Deeth 5 Pending 1 Natural 2 Accident 3 Suicide 4 ☐ Homicide

29b. Signature and title of certified

29a. Certifier

investigetion 6 Could not be

MAR'1"9 1999

28a. Dete of Injury (Month, Day Year) 28b. Time of 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA

syndrome

Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I.

Due to (or as a consequence of):

Due to (or as a consequence of):

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

281. Location (Street and Number or Rurel Route Number, City or Town, State)

condine eschemia

Kan mp

Hospital:

30. Nama and address of person who complated cause of death (Item 23a) (Type, Print) RAJA 4367 Holl/45 att THA

32. Registrar's Signature

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and menner as stated.
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licensa number

D27541

Rd, Ralt, MD - 21227

29d. Date signed (Month, Day, Year)

March 18, 1999

23b. Did tobacco use contributs to the cause of death?

1 Yes 2 No

1 Tes 2 No

24a. Was an sutopsy performed?

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 DYAS 2 No

ew homs

3 Probably 4 Unknown

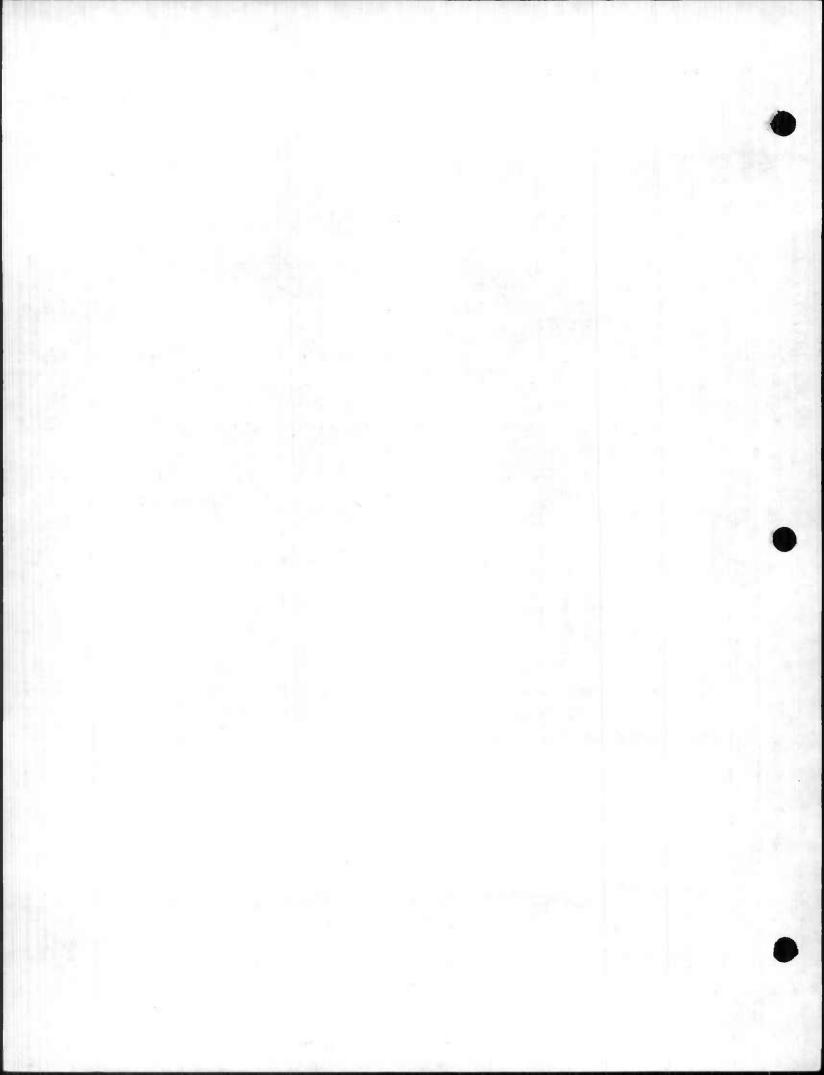
24b. Were autopsy findings available prior to

completion of cause of death?

1 Yes 25 No

MARGLAND

5:30Am



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Death 3 Time of Deeth **Physician** 11-15 PM Ann Kaliyoda March /Medical 4a. Facility Neme (If not Institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen BURNIE ANNE ARUNde HOSDITA NORTH HRUND EL Hours Min. Sept. 30, If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2□XF Year) 1911 Months Deys Maryland 87 Yrs. 215-05-5624 Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director 288-1 Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö must be Items 23a 918 Indian Creek Lane 21032 U.S.A. 14. Race - American Indian, Bleck, White, etc. Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 'natural', or 1□Yes 2□No Spacify: by Specify: 3 Widowed 4 ☐ Divorcad White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Home 8th Important: if item 27 is marked other I any injury or other traumatic event, it pnce. 0 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Sumeme) Be and Mental Peter Milash Ann Lunskis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 918 Indian Creek Lane Crownsville, Maryland 21032 of Disposition (Name o Joseph P. Kalivoda (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cematary, cramatory or other place) 6 1 Burial 2 □ Cremation 3 □ Removel from State Glen Haven Memorial Park 3/17/99 Glen Burnie, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 237 E Patapsco Avenue Balto., Md. 21225

23a. Part1. Enter the disease, or complications that coused the death. Do not enter the mode of Sying, such as calcular or respiratory afrest.

21 225 Avenue Balto., Md. 21225

22a. Part1. Enter the disease, or complications that coused the death. Do not enter the mode of Sying, such as calcular or respiratory afrest. **Physician** MYOCARDIAL INFARCTION 3 DAYS /Medical ACUTE Immediate Ceuse (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): SEPSIS Physician/Medical Examiner 4 DAYS be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of): Due to (or as a consequenca of): 88 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? OLYCYTHEMIA VERA 1 Yes 2 No 3 Probably 4 19 Onknown bengls be del Completed by PERIPHERAL VASCULAR 24b. Were autopsy findings eveileble prior to page 2 should 24a. Was an autopsy completion of ceuse of deeth? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director; p. Be 25. Was case referred to medicel 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 4 ☐ HomicIde To the Hospital of Within 24 hours of To the Funeral D completely tilled i 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year)
March 15 1999 29b. Signeture and title of certifier 29c. License number lin 2, 46962 2

State Registrar

31. Date filed (Month, Day, Year)

M. SHIRAZI, M.D. 32. Registrar's Signature

NORTH

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

ARUNDEL

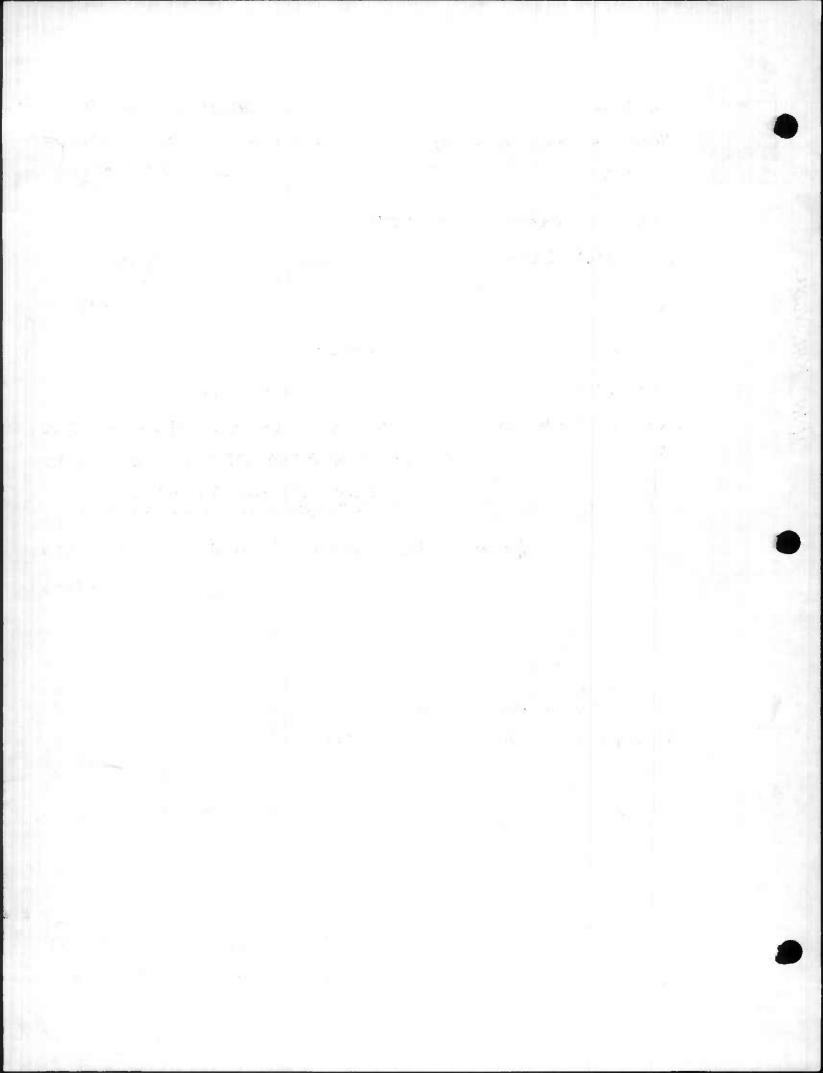
HOSPITAL. MD 21061.

Box 68760

P.O.

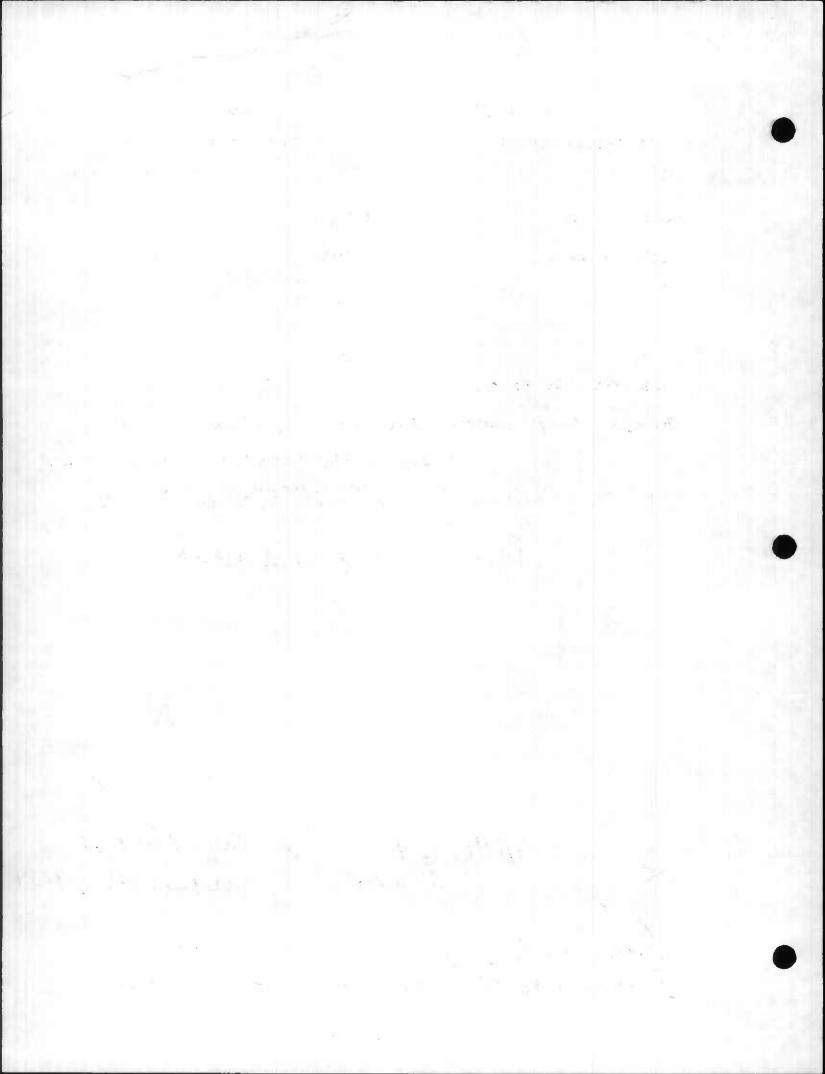
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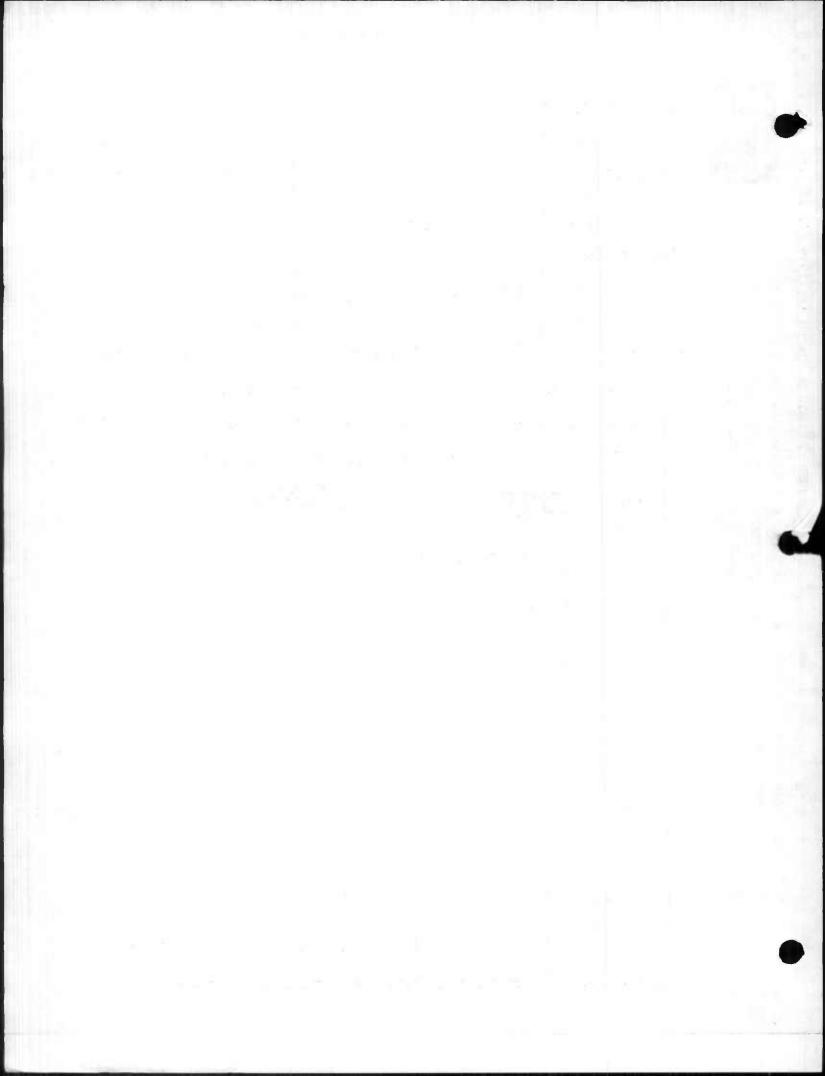


State of Maryland / Department of Health and Mental Hygiene Q Q Q Q Q Q Q

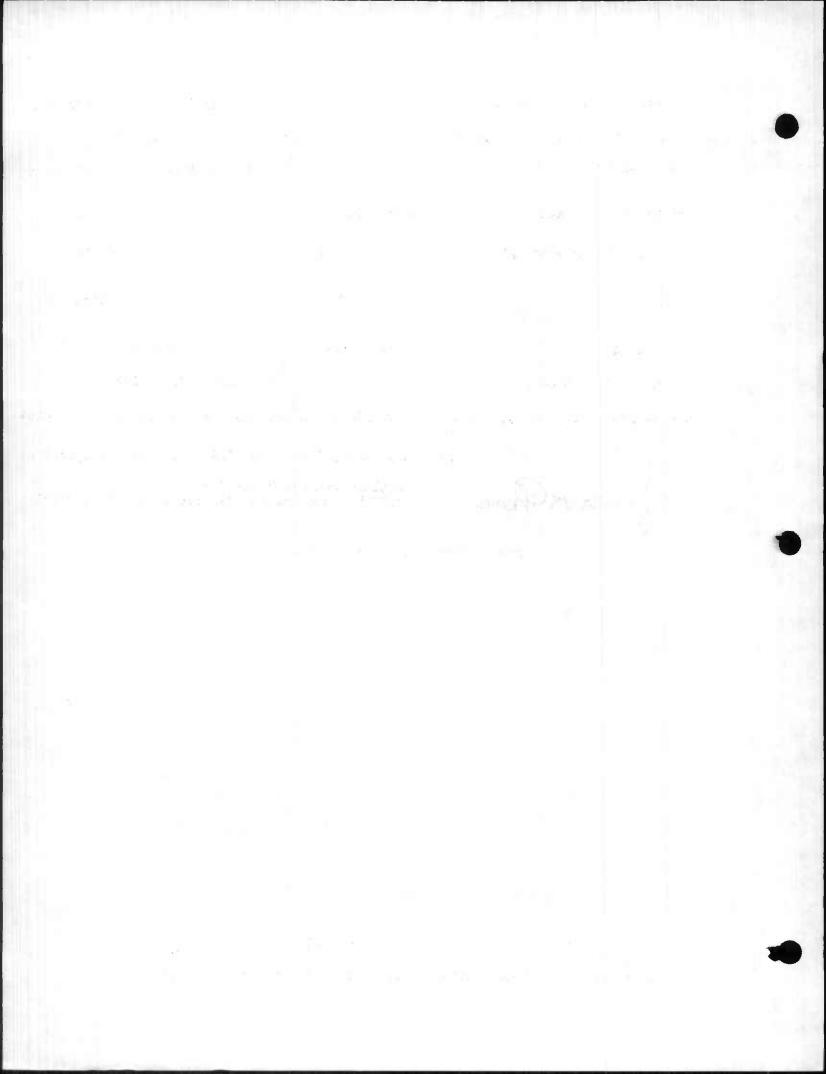
	1. Decedent's Neme (First, Middle, La	st)		ertificate		2. Dete of Dee	th	3.	Time of Death			
Physician	Caitlin Mari					Month	Dey	Year				
/Medical	4e Fecility Neme (If not institution, giv				4b. City. Town o	MARCH Location of Deeth	16, 199 4c. County		1800 PM			
Examiner	JOHNS HOPKINS HO	A STATE OF THE STA			BALTIMO			/A				
Funeral Director	5. Sociel Security Number 6. S 220-53-0516		yrs. last birthdey Yrs.	Months D		s. 8. Date of Birth	Yeer)	*	(State or Foreign			
	Usuel Residence of Decedant 10e. Stete 10b. County	10	c. City, Town or I	conting				104	nside City Limits			
ms 23a or 28a-1 show remait be nothing at neral Director	Maryland N/A	imore			Yes 2 No							
or 22	10e. Street and Number			10f. Zip Co	de	1	log. Citizen of V					
23.	3106 Rosalie Av	e.			234		u.s					
58 E	11. Marital Stetus 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No if Yas, Giva Yeer or Dates:	in U,S. 13	. Was Decedent If Yes, specify	of Hispenic Origin? (Cuben, Mexican, Pue No Specify:	Specify Yes or No- no Rican, etc.)	Specify	a - American II ck, White, etc.				
ed and	15. Decedent's E (Specify only highest gra Elamantary/Secondary (0-12)	ducation ede completed) Collaga (1-4or 5+)	16e. Dec (Giv life.	edent's Usuel O e kind of work d DO NOT use n Infan	one during most of w etired)	orking	16b. Kind of B	usiness/Industi	у			
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end Menta is marked aumatic e	19e. Informent's Name/Reletionship (19b. Mai	ling Address (S	reet and Number or I			State, Zip Coo	fa)			
olther 27 is rr trau	Jennifer A. Kole		310	6 Rosal	ie Ave., E	Baltimore	MD 2	1234				
of Hae	20a. Method of Disposition	2	Ob. Place of Disposeries, cri			Date	20c. Location -		Stete			
nt: if h	Buriel 2 Cremetion 3 C 4 Donation 5 Other (Special	JERROVALITOM STATE				3/22/99	Timoni	um. Mar	uland			
Department of Haelth Important: if fem 27 any injury or other to once.	21. Signeture of Funeral Service Licensee Power A Colored Commune Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236											
	23a. Pert1. Enter the disease, or com shock, or heart failure. List only	plications thet caused the	death. Do not e	nter the mode o	dying, such es cardi	ac or respiretory en	rest,		proximete arval Batween			
hysician /Medical xaminer	Immediate Cause (Finel disease or condition rasulting in daath)	Blust		Pyr	ries of		٨	On	set end Deeth			
physician and is the bunal-transit	Sequentielly list conditions, if eny, leeding to immediate cause. Entar Underlying Couse (Disaasa or injury that initiated evenits	b. Due	to (or es e cons	aquence of):				1				
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ate has been signed page 2 should be del	6=1					24e. Wes o		eveilat	eutopsy findings ble prior to ation of cause th?			
page 2 s						X	es 2□No	De Ve	s 2 No			
this certificate ral director, par	25. Was case referred to medical exeminer?					aath (Check only o	ne)					
0 0	XXX Yes 2□ No	Hospitel XX npatient	2 ER/Outpati			Home 5 ☐ Resid	and the second second second					
wher the unera	27. Mannar of Death 1 □Naturel 5 □ Panding	28a. Data of Injury (Month, Qay Ye			Injury et Work?	28d. Describe h	ow injury focus	red	1			
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within 24 hours after death. To the Funeral Director: After thi complataly filled in by the funeral Medical Certification: 1		nysician: To the best of m niner: On the besis of exa and mennar statad.										
within 24 hours of To the Funeral Completely filled	29b. Signature and title of certifier	and monitar stated.		29c. Li	cense number		29d. Dete signe	d (Month, Dav	, Year)			
¥ F 8	14	1	\	300. 20			ARCH 17		dia.			
	1 Tala	meny)		OCME	IVI	ARCH 1/	, 1777				
	30. Name and address of person who	complated cause of death			, Baltimo	35- 3		0.1				



			State of Marylan		irtment of F tificate of			giene Reg. No.	0	8961
	Physic /Medi	cal	Decedent's Neme (First, Middle, Last) KENNETH GEORGE KRINER				2. Dete of Dec Month March	16, 199		3. Time of Deeth 12:25 p.m
	Examil Funeral Director	ner	4e. Fecility Name (If not institution, give street end number) Stella Maris Hospice 5. Sociel Security Number 178-14-8188 1 □ M 2 □ F 80	lest birthday) Yrs.	If Under 1 Year Months Deys	4b. City, Town, or Lo Tows on If Under 24 Hrs. Hours Min.	8. Date of Birt Month, Day	Balt	imore	ece (State or Foreign V) USYLVANÍA
	ehow	Ē		y, Town or Lo	cation					d. Inside City Limits
	death with the Marylend ms 23a or 28a-1 show rmust be notified at	Funeral Director	Maryland Harford Abi 100. Street and Number 3119 Deer Creek Drive			10g. Citizen of V	1 ☐ Yes 2 🕅 No izen of What Country?			
070	or ite		11. Marital Stetus 1 Never Married 2 Married 3 Widowed 4 Divorcad 12. Wes Decedent Ever in U, Armed Forces? 1 N Yes 2 No If Yes, Give WWII	11	Vas Decedent of H Yes, specify Cuba	tispenic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rac	e - Americe ck, White, et	tc.
21215-0020	I within 72 hours iene. • then "netural", the Medical Ex	Completed by	15. Decadent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) 12th grade	16e. Deced (Give I life. E	ent's Usuel Occup kind of work done OO NOT use retired CL Offic	during most of worki d)	ing	16b. Kind of Bi	usiness/indu	ustry
ryland ?	nould be filed I Mental Hyg narked other natic event,	To Be C	17. Fether's Neme (First, Middle, Last) Benjamin F. Kriner	18. Mother's Neme Sophia M	Law Enforcement me (First, Middle, Maiden Sumeme) McManigle					
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other treumatic event, the Medical Ance.		19e. tnformant's Name/Relationship (Type, Print) Deborah Gray (Daughter) 20e. Method of Disposition 1□ Burial 2 🛱 Cremation 3 □ Removel from Stete	3119		end Number or Aure ek Drive,			. 210	009
Baltim	permit. Pag Department Important: I any Injury o		4 Donetion 5 Other (Specify) 21. Signeture of Funerel Service Licansee Made T. Zavga	22	nt Crema Name end Addre himunek					Maryland •
	Physician /Medical Examiner	her	23a. Pert1. Enter the disease, or complications that caused the deeth shock, or heert failure. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in deeth) Due to (or	i. Do not ente	a the mode of dyli	ng, such es cardiac o	or respiretory er	rest,	i i	Approximate ntervel Between Onset and Deeth
x 68760,	death certificate be executed e attending physician end of for use as the burial-transit	/Medical Examiner	if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury	r es e consequ as e consequ						
.O. Box	0 0 6	Physician/M	Pert II. Other significant conditions contributing to death but not resu	ulting In the un	derlying cause giv	en in Pert I.				the cause of death?
Records, P.	requiras been signi should be	Completed by P					24a. Wes a		24b. Were evell com	e eutopsy findings leble prior to pletion of cause sath?
Vital Re	The ate h	Be Comp	25. Was case referred to medical			28. Piece of Death		es 210 No		Yes 2□ No
Division of V	r Attending Physical Control of the death.	Certification: To B	examiner? 1 Yes 2 X No Hospitel: 1 Inpetient 2 I 27. Manner of Deeth 1 X Naturel 5 Pending Investigation 3 Suicide 6 Could not be determined 4 Homicide Hospitel: 1 Inpetient 2 I 28a. Dete of Injury (Month, Dey Year) 28a. Place of Injury - At ho building, etc. (Specify	ER/Outpetient 28b. Time of Injury me, ferm, stre	28c. Injur Work M 1	er: 4 \sum Nursing Hor y et k? Yes 2 \sum No	me 5 Resid 28d. Describe h	ence 6 10th ow Injury occurrence treet end Numb	red	HOSPICE Route Number,
	To the Hospital or within 24 hours effe To the Funeral Dir complately filled in	edicai	29a. Certifier (Check only one) 1⊠ Certifytng Physician: To the best of my know 2 ☐ Medical Examiner: On the basis of exeminet end menner stated.	vledge, deeth ion end/or Inve			T			
	To To Con	W	30. Name and eddress of person who completed cause of deeth (Item	23e) /Tune F		3725		3) / 6		ay, Year)
1	Sta Registr		DR. TARIQ MAHMOOD 2300 DULANI 31. Dete filed (Month, Dey, Year) MAR 1 9 1999	EY VALI		TIMONIUM,	MD 210)93		



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** March 10 Dey 1999 eer Clara Ε. Lester 8:38am /Medical 4e. Fecliity Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard Howard County General Hospital 5 Social Security Number If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) May 8, 1909 9. Birthpiece (State or Foreign Country) Michigan 7. Age (In yrs. last birthdey) **Funeral** 1 M 2 XF Deys Hours 89 382-09-0409 Yrs. Director Usuei Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Maryland N/A Baltimore 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6 21229 United States 820 S. Caton Avenue Apt. 5C itema 23a death Funer 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. 72 hours after 1 □ Never Merried 2 □ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: "natural", or þ White 3 X Widowed 4 Divorced nd 2 should be filed within 72 hou alth end Mental Hygiene. 27 is marked other than "natural r traumatic event, the Madical E Completed 15. Decedent's Education 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Secretary permit. Pages 1 and 2 should be file Depertment of Haaith and Mental Hy Important: if Item 27 is marked other eny Injury or other traumatic event since. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth B. Henry Crowell 01ka 19a, Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Marguerite R. Telford/Sister-in-100 W. Hickory Grove Road Bloomfield Hills, MI48304 law 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 XCremetion 3 ☐ Removei from Stete Metro Crematory, Inc. 3/17/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. mag 4107 Wilkens Avenue Baltimore, Maryland 21229 Manita 1 Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, or heart failure. List only one ceuse on each line. Approximete Onset end Death **Physician** /Medical Immediate Ceuse (Final Atherosclerotic Heart Disease disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner that the death certificate be axecuted and -tran Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): bunial Box 68760. physician Physician/Medical the Due to (or as e consequence of) signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ The law requires 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy pertormed? Completed page 2 has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician: 24 hours after daath. Funeral Director: After this certificately filled in by the funeral director, p. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitai: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide To the Hospital or with 24 hours aft To the Funeral Diccompletely filled in 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) and menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated. 29a. Certifier Medical (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D47683 aymord MI 30. Name and address of person who completed cause of death (Itam 23e) (Type, Print)
Raymond Miller 25 Main Street Suite 200 Reisterstown, Maryland Raymond Miller 31. Dete filed (Month, Day, Year) 32 Registrer's Signeture State MAR 1 9 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** Georgiana J. Lynch March 17 1999 9:20 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Meadows Glen Arm Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Data of Birth (Month, Day, Year) Funeral 1 M 2 F Hours Min. Days Months 215-54-2634 Director 86 June 7 1912 Virginia Usual Residence of Decedent the Maryland 10a. Stata 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or home 23s or 28s-f show traumatic event, the Medical Examples must be notified at 10b. County 1 Yas 2 No Director MD Baltimore Glen Arm 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? with 11630 Glen Arm Road USA 21057 Funeral deeth 12. Was Decedent Ever in U,S. Armed Forcas?

1 Yas 2 XNo
If Yas, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Stalus Black, Whita, etc. 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mentel Hyglene.
Important: if item 27 is marked other than "nationy or other traumatic event, the Madian price. Elementery/Secondary (0-12) College (1-4or 5+) Artist Fine Art 12 18. Mothar's Nama (First, Middle, Maiden Sumema) 17. Father's Nama (First, Middle, Last) Walker Jones Elizabeth Lewis Selden 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) John Lynch/Son 15103 Priceville Rd., Sparks, MD 21152 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other place) Data 20c. Location - City or Town, Stata 1 X Burial 2 Cremation 3 Removal from Stala
4 Donation 5 Other (Specify) 3/20/99 Dulaney Valley Memorial Gardens Timonium, MD 22. Nama and Addrass of Facility Lemmon Funeral Home 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Timonium, MD 21093 Approximata Intarval Batween Onset and Death **Physician** Immediala Causa (Final disease or condition resulting in death) /Medical ears toge dementia Examiner Dua to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-transit The lew requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediala cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760, Dua to (or as a consequence of): P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown disease rtery Records, by 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Be Completed has 1 Yas 2 No 1 ☐ Yas 2 ☐ No this certificate of Vital 25. Was casa referred to medical 26. Place of Deeth (Check only one) 1 ☐ Yes No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien1 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) edical Certification: To 28a. Date of Injury (Month, Day Year) funerai 27. Mannar of Death 28c. tnjury at Work? 28d. Describe how injury occurred After Division Hospital or Attanding 5 Pending investigation 1 Natural 2 Accident s after death.

I Director: After din by the fur 1 Yas 2 No 3 ☐ Suicide 6 Could not be determined 281. Location (Street end Number or Rural Route Number, City or Town, Steta) 28e. Place of Injury - At homa, Ierm, street, lactory, office building, etc. (Specify) 4 ☐ Homicide hours after 24 hours Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to tha cause(s) and mennar es stated.

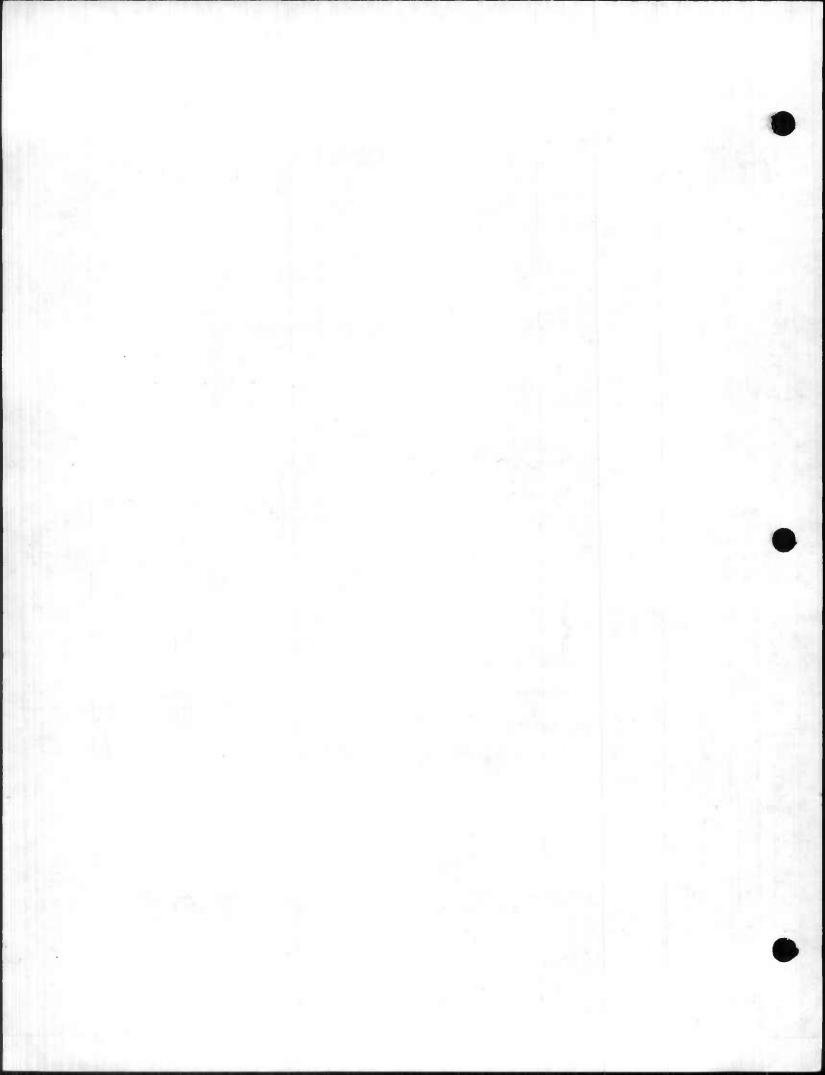
Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to tha causa(s) and manner stated. 29a. Cartifier To the Fune completely f (Check only one) To the F within 2 29c. Licanse number 29d. Data signed (Month, Day, Year) 29b. Signalura and titla of certifier March 17, 1999 mo Ceri 30. Name, and addrass of person who completed causa of death (Item 23a) (Type, Print) N. Charles St. Balto. mo 21204 6-BMC 6701

DHMH 16 Rev 6/95

State Registrar

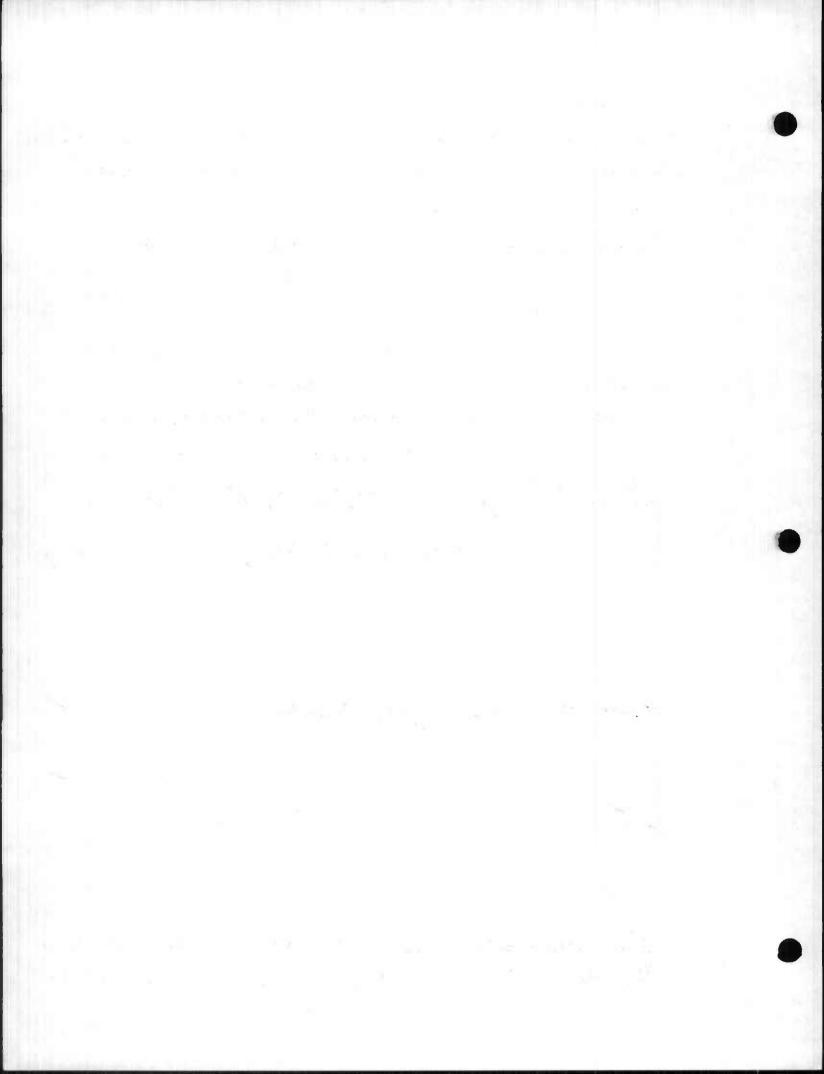
31. Data filed (Month.

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1. Decedent's Name (First, Middle, L	ast)			tificate of		2. Data of De			3. Time of De		
Physicia /Medic	_	ROSE M. MUSTIN			MARCH								
Examiner		4a. Facility Name (If not institution, gr		4b. City, Town, or L	ocation of Deal	T	County of Death						
		GENESIS ELDERCA	RE HAMMO	NDS LA	NE		BROOKLYN	PARK	AND	VE ARUNI	DEL COUN		
Funeral Director		218-03-9696	Sex 7 1 □ M 2 □ XF	'. Age (In yrs.	89 Yrs.	If Under 1 Year Months Days	Days Hours Min. (Month, Day, Year)				nplace (State or F untry) yland		
*_		Usual Residence of Decedent 10a. State 10b. County		10c Cit	ly, Town or Lo	cation				Т	10d Incide City I		
r 28a-f show notified at	JO.	Md. n/	a		Baltimo						10d. Inside City i		
ms 23a or 28a crount be not	al Director	10e. Street and Number 120 East Barney	21230	10g. Citizen of What Country? USA			untry?						
al', or ite	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 □ No If Yas, Give X Year or Dates:				Vas Decedent of h	ont of Hispanic Origin? (Specify Yes or No- y Cuban, Mexican, Puerto Rican, etc.) 14. Race - America Black, White, e						
iene. r than "netural", the Medical Exe	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	rade completed) Collega (1-4	4 or 5+)	lifa. L	lent's Usual Occup kind of work dona DO NOT use retire	rk dona during most of working se retired)			16b. Kind of Business/Industry Home Owner			
her it,		17. Father's Name (First, Middle, Las	(t)		HOME	ananci	18. Mother's Nam	e (First Middle			-		
200	o Be	John Gardner	,				Ann Mor		, 111210011	Jamanay			
h and Mental I	2	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	a Addrass (Street	and Number or Run		ner City or	Town State 7	in Code)		
		George Lowe		on)			street,						
ent of H it: If iten y or oth		20a. Method of Disposition 1 Burlai 2 □ Cremation 3 4 □ Donation 5 □ Other (Speci		tato	cemetery, crem	sition (Name of natory or other pla L1 Cemete		Date /20/99		eation - City or T	Town, State		
Departm Importar any injur				1 ,						4	,		
Depa Impo any ir		21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 E. Fort ave., Baltimore, Md. 21230 23a. Patri. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inflevel Better and Polyniak Funeral Home P.A. 23a. Patri. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inflevel Better Bette											
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xaminer		Immediata Cause (Final disease or condition resulting In death) Due to (or as a consequence of):											
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certificate has rector, page 2	E							40	v. al	_			
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ter thi		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of (Month,		28b. Time of Injury	28c. Injui Woo	T T	28d. Describe			iny)		
within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	Certification:	3 Suicide 6 Could not to determined	28e. Place of	f Injury - At ho g, etc. (Specif	ome, farm, stre	eet, factory, office							
in 24 hou he Funer pletely fill	Medical	29a. Certifier 1 ☐ Certifying Pl (Check only one) 2 ☐ Medical Exa	hysician: To the bas miner: On the bas and manna	is of axamina	wladga, death tion and/or Inv	occurred at the tir estigation, in my	me, date and placa, opinion, death occurr	and due to tha rad at tha tima,	cause(s) a date and p	and manner as place, and dua	stated. to the cause(s)		
	Σ	29b. Signature and tittle of certifier	/	2		29c. Licens	_			-			
To To									29d. Date signed (Month, Day, Year) Manh, 19, 1999 BG 1/2, MID 21236				
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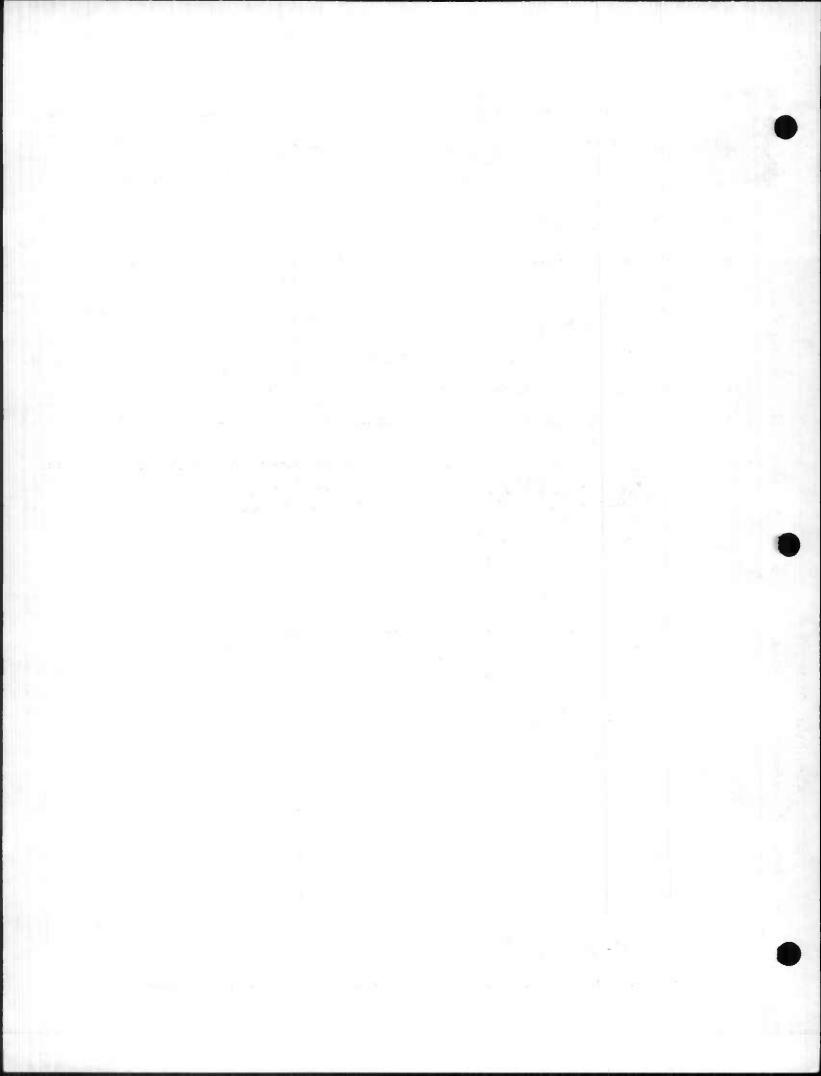


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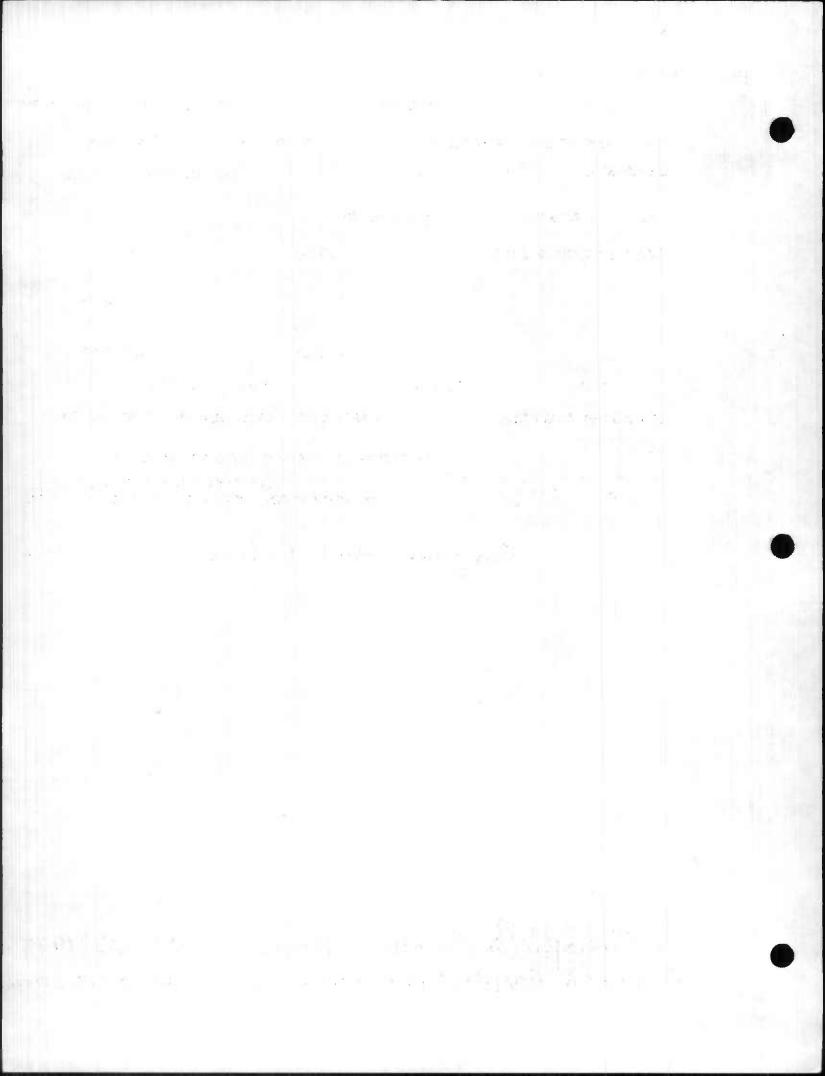
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McLaughlin,

NAME:

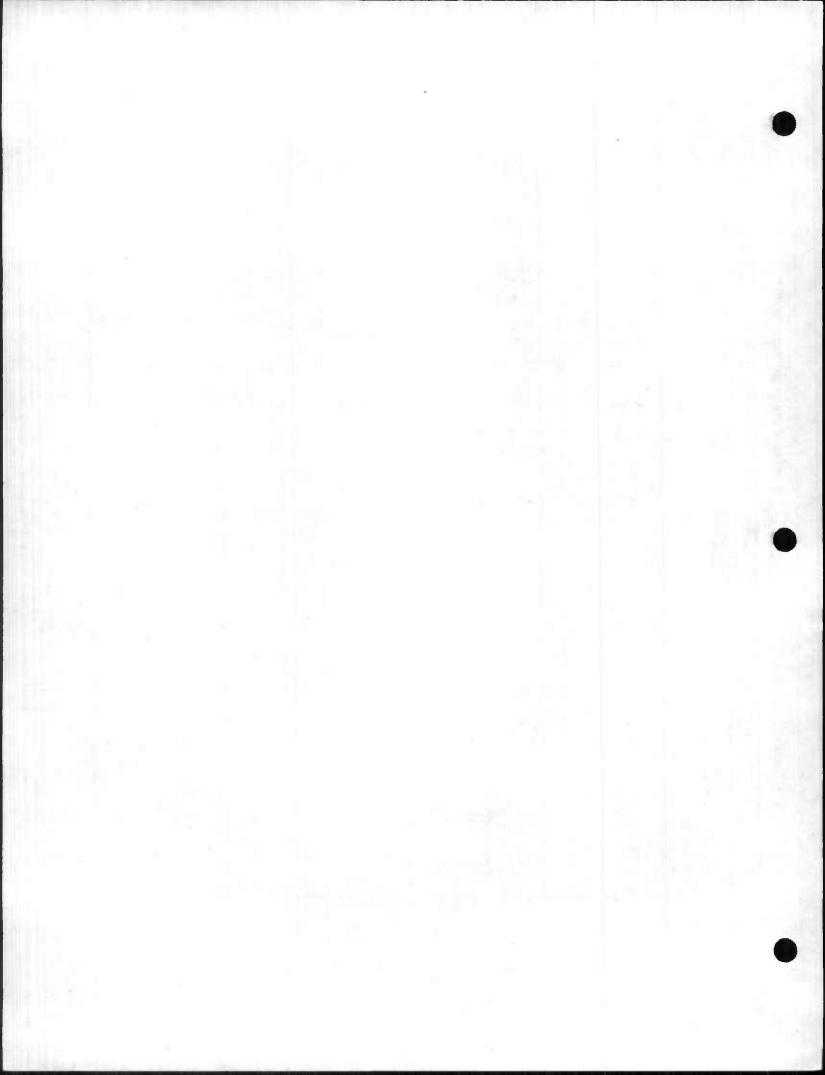


	PER MD G769 3-19-99 1. Decedent's Name (First, Middle,				1124		2. Date of Death	Day	Year	3. Time of Death		
sician edical	LILY		MC	DIANO			MAR. 9,	1999	Tear	10:45 AM		
miner	4a Fecility Neme (If not institution,	give street end num	ber)			4b. City, Town, or Lo	cation of Death	4c. County	of Death			
_	HEBREW HOME OF			1 1476	nder 1 Yeer	ROCKVILLI If Under 24 Hrs.	8. Date of Birth	MONTO				
eral tor	218-68-3705	1□ M 2√ F	. Age (In yrs. last	Yrs. Mont		Hours Min.	(Month, Dey, MAY 20,			ace (State or Foreigy) EECE		
rector	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Location					10	d. Inside City Limit		
tor	MD MONTGOMERY SILVER SPRING									1□Yes 2□XN		
lec	10e. Street and Number			10f.	Zip Code		10	g. Citizen of W	/het Count	ry?		
a D	12701 SPRINGTE	REE DRIVE			20	904		ITA	LY			
by Funeral Director	11. Marital Stetus 1 Never Married 2 Marrie 3 W Widowed 4 Divorced	Armed Ford	₩ No		ecedent of the specify Cubo	dispanto Origin? (Spe en, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ice - American Indien, ack, White, etc.			
	15. Decedent's	Education		6a. Decedent's U	Jsuel Occup	petion	1	6b. Kind of Bu				
Be Completed	(Specify only highest Elementery/Secondery (0-12)	grade completed) College (1-	4or 5+)	life. DO NO	Tuse retire		ng					
Con	12		HOMEMAKER						IN HO	ME		
To Be	17. Father's Name (First, Middle, L DANIEL	18. Mother's Name	Name (First, Middle, Meiden Sumeme) OSA GATTEGNO									
n 27 is m	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12701 SPRINGTREE DRIVE, SILVER SPRING, MD 20904											
	20e. Method of Disposition 1 Surial 2 Cremation	Dete 2 3/10/99	Oc. Location -									
	4 Donation 5 Other (Special Service Li		DET	The second secon								
		129				ess of Fecility SOL TERSTOWN 1				INC. MD 21208		
edicai Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate couse. Enter Underlying Cause (Disease or Injury that initiated events	b	Due to (or es	a consequence e consequence e consequence	of):	Fail			1			
Physician/Medi	resulting in deeth) Lest Part ff. Other significant condition	ds contributing to dea				ven in Part I.	23b. Dfd tob	eacco use cor	ntribute to	the cause of deat		
by Phy										ably 4 Unkno		
Completed t							24a. Was an perform	autopsy ed?	con	re autopsy finding ilable prior to npletion of cause leath?		
Con							1 ☐ Ye	2 12 No	1 🗆	Yes 2□ No		
I director	25. Was cese referred to medicel examiner?	Hospital:			Ott	26. Place of Deat	h (Check only one)				
	1 Yes 2 No	1 L In	-		DOA	4 Hursing Ho	me 5 Resider)		
cation	1 Natural 5 ☐ Pending 2 ☐ Accident investigs	(Month	(Month, Dey Year) Injury Work? Injury M 1 ☐ Yes 2 ☐ No						28d. Describe how injury occurred			
edicai Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						281. Location (Str City or Town,		er or Hurai	noute Number,		
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edica		A 1/1	34.1		29c. Licens	se number	29	d. Date signed	d (Month, L	Day, Year)		
Medical Certificat	29b. Signature and title of certifier	a You	from 1	MD	0:	24942		\$3-	49	-1990		



State of Maryland / Department of Health and Mental Hygiene 99 08967

			Cert	ificate of	Death		Reg. No.	00001			
	1. Decedent's Name (First, Middle, La					2. Date of D		3. Time of Death			
Physician	BARBAN	2A M	AJOR	IELLO		Month	. 16 1-6	ear 0330			
/Medical Examiner	4a Facility Name (If not institution, give	re street and number)	pital		1	or Location of Dea					
Funeral Director	5. Social Security Number 6. S		: last birthday)	If Under 1 Year Months Days	If Under 24 h	Irs. 8. Date of B	irth (9)	Birthplace (State or Foreign Country) Pennsylvania			
	Usual Residence of Decedent	0,				TIPLII	15, 1747	Temoyivania			
deeth with the Maryland ms 23s or 28s-f show ment be notified at neral Director	Maryland Prince (ity, Town or Loca owie			10d. Inside City Limits XIX Yes 2 □ No					
with the Ma	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	it Country?			
h wit	12303 Melling Lar	ne		20715		4	United S	States			
2 2 2 2	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		es Decedent of I Yes, specify Cub		(Specify Yes or Nerto Rican, etc.)		American Indien, White, etc. White			
21215-002C d within 72 hours at plens at the "natural", or the baseline from the testing at the	15. Decedent's E		16a. Decede	nt's Usual Occu	pation		16b. Kind of Busin	ness/Industry			
od within 72 ho yglene. Ser then "natural," the treatest	(Specify only highest gro	ade completed)	(Give ki	nd of work done NOT use retire	during most of	working					
then the month of the series	Elementary/Secondary (0-12)	College (1-4or 5+)	Homer	maker			Own Home	2			
be file be file d other avent.)			18. Mother's h	Varne (First, Middle	e, Maiden Sumame)				
Vian Wented with a Ride av					Ethel	Huyett					
Aar she seum	19a. Informant's Name/Relationship (Joseph T. Maior:				and Number or	Rural Route Num	ber, City or Town, Stary 1 and 207				
Baltimore, North Pages 1 and Jopannent of Health moorant: If Health my Injury or other trucks.	20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specia	20b.	Plece of Disposit cemetery, crema chwarzwa	tion (Name of atory or other pla	∞) March	20, Date 199	Jacksonw	y or Town, Stete			
Baltimo pemil. Page Department of important: If is eny injury or page.	21. Signature of Funeral Service Licer		22.1	Name and Addre	ess of Facility	Funeral H	lome, Inc.				
_ 20202	Muchando.	Aguar	16	000 Anna	apolis I	Rd. Bowie	Maryland				
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea one cause on each line.	ith. Do not enter	the mode of dyi	ng, such as card	fiac or respiratory	arrest,	Approximate Interval Between			
Physician				0				Onset end Deeth			
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)			Dehy	drate	on		days			
i i		Due to ((or as a conseque	ence of Ele	ctole	ite in	balem	e days			
58760, leate be assented physicien end s the burial-transit		Due to (or es a conseque	ence of):) band	ers con	7	Years			
68760, Meate be as a physicien es the burie	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):	1		- 51/0				
Box 68760, ath certificate be a strending physicien for use as the buristic lanyMedical E		d	myo	gs tro	rophy year						
death death of for w	Part II. Other significant conditions of	contributing to death but not re	sulting in the und	lerlying cause gi	ven in Pert I.	23b. Die	f tobacco use contri	bute to the cause of death?			
S, P.O. BO) se that the death or gned by the attend be detached for use by Physician/						10	Yes 2 No 3	Probably 4 Unknown			
Cord						24a. Wa per	s an autopsy formed?	24b. Were autopsy findings evailable prior to completion of cause of death?			
	The state of the s					10	Yes 2 No	1 ☐ Yes 2 ☐ NO			
f Vital Re yelclen: The list certificate had director, page for Be Com					26 Plans of I	Death (Check only		7			
Of VItal Physician: T this certificat rai director, p	examiner? 1 Yes 2 No	Hospital: 1 Impatient 2E] ER/Outpatient	3 DOA O	hor		sidence 6 Other	(Specify)			
VISION Of Attending Physical death. ector: After this by the funeral of iffication: To		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju		-	how injury occurred				
DIVISION C tall or Attending P as that death. Is Director: Ahar t is In by the funeri Certification:	3 Suicide 6 Could not be determined		home, ferm, stree ify)	et, fectory, office			281. Location (Street and Number or Rural Route Number City or Town, State)				
Hospi Runer Funer Hely fill	29a. Certifier 1 Certifying Pt (Check only one)	nysician: To the best of my kn niner: On the basis of examin and manner stated.									
Mediting Mediting	29b. Signature and title of certifier	1		29c. Licen	se number		29d. Date signed (Month, Day, Year)			
F 3 F 8	11-4			Da	2899	8		12/1999			
	30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Pr	rint) Pr	RITAN	n s.	MD 2				
	7101 0	berry L	NA	211,	Lac	nel	MD 2	-0/00			
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	J. J.	print							



WRC 991629-005 ARTHUR F. **MERCERON**

> **Physician** /Medical

Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f ahow traumstic event, the Medical Examinat must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural, or the Bary Injury or other traumatic event, tra Medical Examina

Baltimore, Maryland 21215-0020

death with the Maryland

Director

Funeral

by

Completed

Be

			Cer	tificate	of I	Death			Reg. No.		
1. Decedent's Neme (First, Midd	Arthur	Frank N	iercer	on			The Co	2. Dete of D Month MARCH	eath 17,	1999°	3. Time of Death 3.46 PM.
4e Facility Neme (If not Institution	on, giva street end n				4	-0.	wn, or L	ocation of Dee		ounty of D	
5. Sociel Security Number 215-28-5872 Usuel Residence of Decedent	ociel Security Number 6. Sex 7. Age (In 15 - 28 - 58 7 2 X X 7 0				1 Year Deys	If Under Hours		6. Date of B (Month, D	irth ey, Year)	9.	imore Birthplace (State or Foreig Country) aryland
10e. Stete 10b. County	ltimore		, Town or Lo	cation							10d. Inside City Limits
10e. Street and Number 639 Murdock	Road			10f. Zip (212	212			10g. Citize	USA	Country?
11. Marital Status 1 Never Merried Marital 3 Widowed 4 Divorced	Armed F	2 Nores	in .								
15. Deceder (Specify only higher Elementery/Secondery (0-12)	() (1-4or 5+)	16e. Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired) Auditor					Board of Education				
17. Fathar's Nema (First, Middle, Frank M	(Last) erceron		34403			18. Moth		e (First, Middl	e, Maiden Su	meme)	
19e. Informent's Neme/Reletion Diane B. Merce				-				al Route Num			te, Zip Code)
20e. Method of Disposition 1 Burial 2 Cremetion 4 Donetion 5 Other (3		n State C	iece of Dispo ematary, cren tro Cr	netory or ot	her pled		03	Date /10/00			or Town, State

MD 21228

3 Probably 4 Unknown

24b. Wara eutopsy findings evailable prior to complation of causa of deeth?

18 Yes 2 □ No

281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 639 Munder IT Read

29d. Dete signed (Month, Dey, Year)

MARCH 18, 1999

Approximate Intervel Between Onsat and Death

Physician /Medical

Examiner physician and s the burief-transit The law requires that the death certificate be executed attending pl

Examiner

Physiclan/Medical

by

Completed

Be

Certification: To

edical

3 Suicide

29e, Certifier (Check only one)

4 Homicide

signed by the at d be deteched for page 2 s certificate To the Hospital or Attending Physician: funeral director, 24 hours after death. Funeral Director: After this within 24 hours after deared to the Funeral Director completely filled in by the

Division of Vital Records, P.O. Box 68760.

Dawn 299 Frederick Rd. Baltimore, 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiretory errest shock, or heert feiture. List only one ceuse on each line. Immediate Ceuse (Final disaase or condition resulting in deeth) Asphyxiation food spication Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yes 2 No Cerebral vascular accident 24e. Wes an autopsy performed? alzheimens disease 1 Yas 2 □ No 25. Wes cese referred to medical axaminer? 26. Plece of Death (Check only one) Hospitel: Other: 4 Nursing Homa 5 N Residence 6 Other (Specify) XX Yes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury at Work? Found 1542 1 ☐ Neturei 5 Pending subject choked on food 1 Yes 2 No investigation 3-17-99 2 Accident

State Registrar

5. Stephen S.
31. Date filed (Month, Day, Year) MAR 1 9 1999

29b. Signature end title of certifier

6 Could not be determined

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Radentz 111 Penn Street, Baltimore, Maryland 21201

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Residence

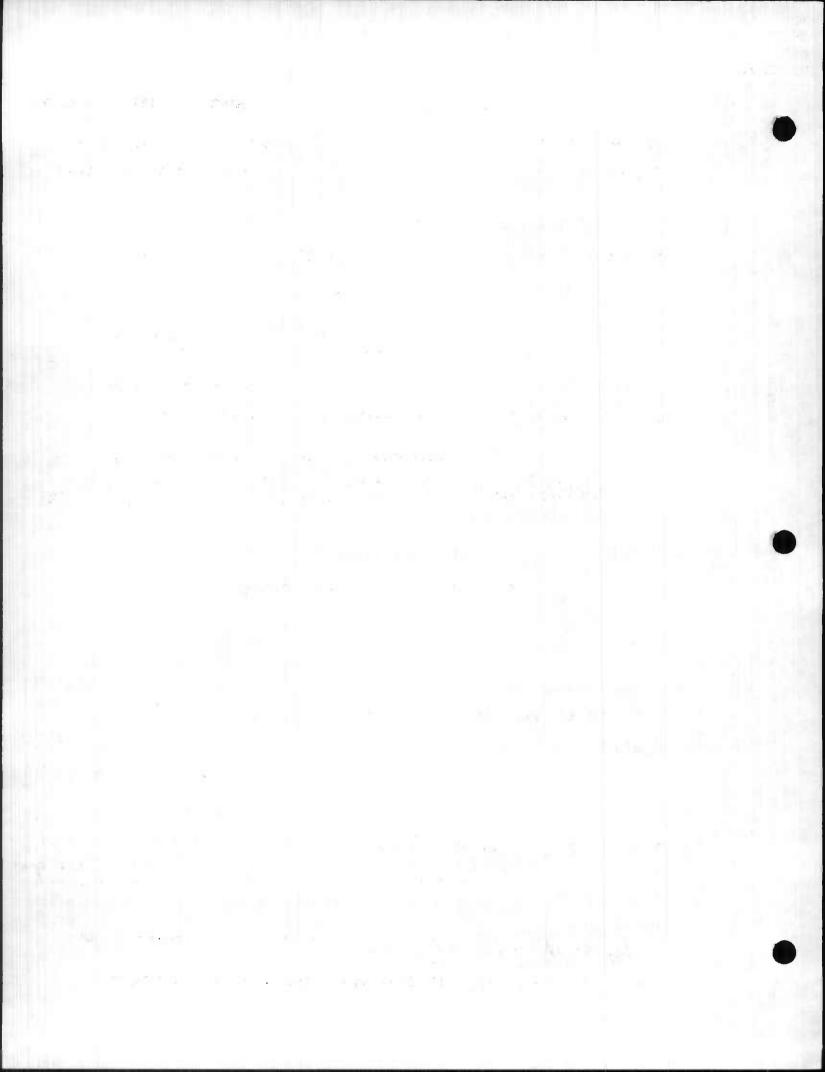
Baltimere County, Maryland

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Miller Elsie March 17 1999 12:10 PM /Medical 4a Facility Nama (If not institution, giva street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Genesis Elder Care Randallstown Center Randallstown Baltimore Hours Min. 8. Data of Birth (Month, Day, Year)

April 22,1910 If Under 1 Yaar Birthpleca (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Deys 1□ M 25 F 218 01 8808 88 Director Maryland Usual Residence of Decedent 10a. Stete 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 XYas 2 □ No Maryland n/a Baltimore Directo r than "natural", or items 23s or 28s-f the Medical Examiner must be notifie 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 524 N. Charles St. 21202 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedenf Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Giva Yeer or Detas: 14. Race - American Indian, 11. Marital Status Bleck, Whita, etc. 1 Never Merried 2 Married 1□ Yes 2□ No White Maryland 21215-0020 Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent'a Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Care Giver Health Care 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Nema (First, Middla, Last) 22 should be fi h and Mental H 7 is marked of Be Albert Miller (Unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any Injury or other traus Carol Friedman / Niece 1632 E. Baltimore St., Baltimore, MD 21231 Saltimore, 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2X Cremetion 3 ☐ Removel from State Green Mount Crematory 3/18/99 4 □ Donetion 5 □ Other (Specify) Baltimore, MD 22. Neme and Address of Fecility CAFA Stephen D. Lohrmann P.A. Daman 8717 Green Pastures Dr., Baltimore, MD 21286 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiretory errest, shock, or heart teilure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Sequentially list conditions, if eny, leading to immediefe cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? be detached the 1 Yes 2 No 3 Probably 4 Unknown signed by DNIGFFICIENC Records. by 24a. Was an autopsy performed? 24b. Were autopsy tindings eveilable prior to Completed completion of cause of death? certificate has 1 ☐ Yes ,2 → NO 1 Yes Division of Vital 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) 8 To Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: All Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 □ 28a. Dete of Injury (Month, Day Year) uneral 27. Manner of Box 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation death. 2 Accident 1 Yes 2 No Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, streef, fectory, office building, etc. (Specify) or A 4 Homicide Hospital of To the Hospital edical 29a. Certifier (Check only one)

18 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated.

29b. Signeture and title of certifier

29d. Date signed (Month, Dey, Year)

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

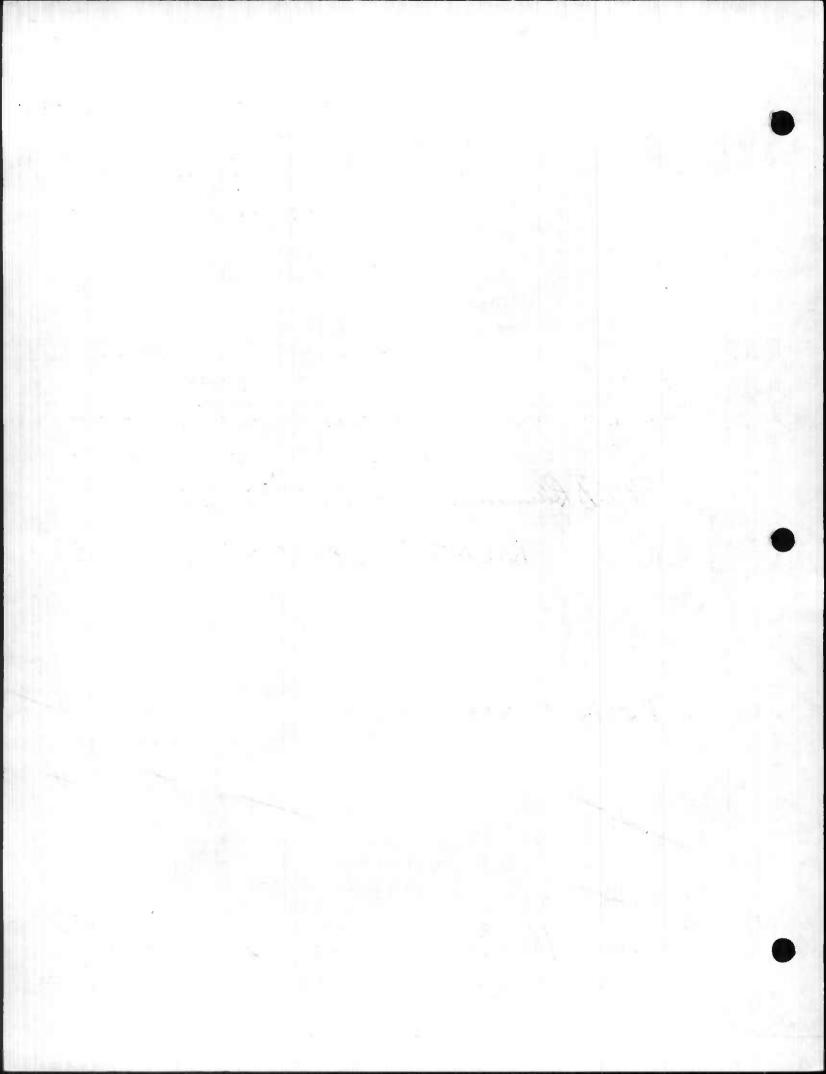
3+ GAGGNTAGE ND

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 16 Rev 6/95

State Registrar

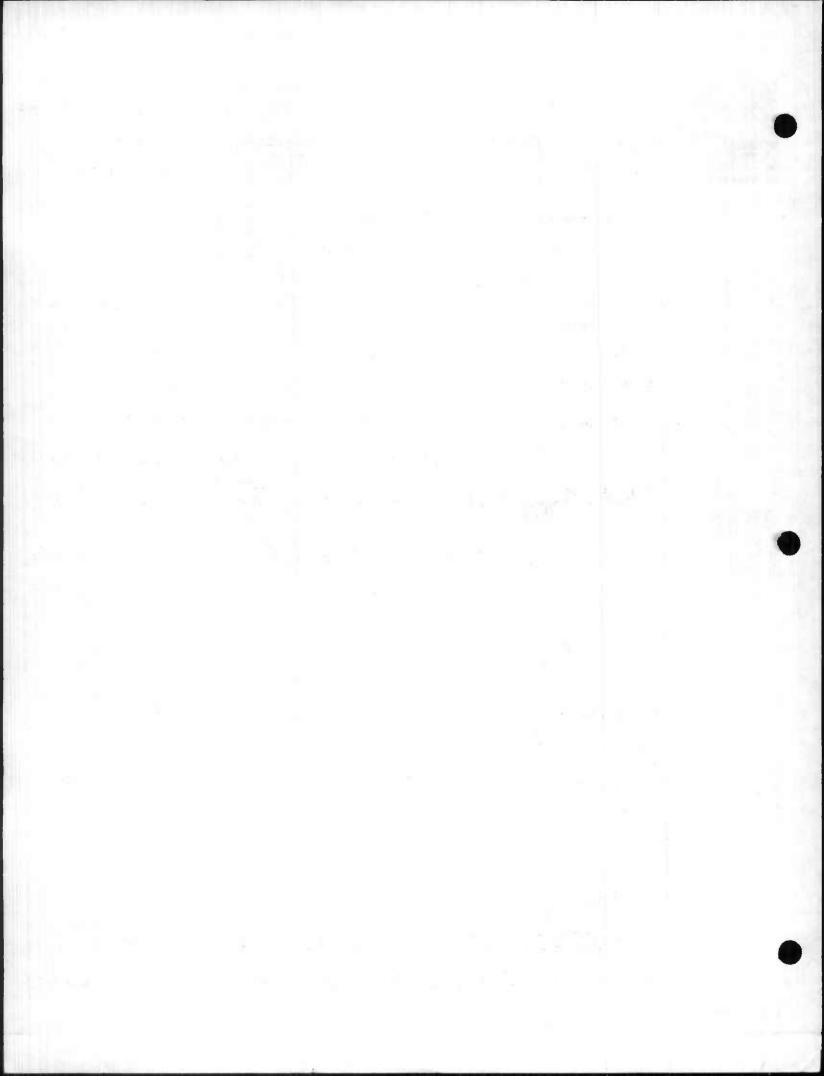


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Month Lillian C. Nolan 1201 AV 3 /Medical 4e. Fecility Name (If not institution, give street end number) 4b City Town or Location of Death 4c. County of Death Examiner Chesapeake Woods Center Dorchester Cambridge If Under 24 Hrs. 6. Date of Birth
Hours Min. (Month, Day, Year)
March 14,] If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 □ F Yrs 214-38-4068 90 1909 Maryland Director Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Madical Examiner must be notitied at Director Cambridge 1 ■ Yes 2 □ No Dorchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 315 Oakley Street 21613 hems 23a USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status 14. Rece - American Indian, permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or hen any injury or other traumatic event, the Medical Examples Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Sales Associate Retail 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be George Frank Lillian Langemann 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Bernard J. Nolan, III, Son P. O. Box 796, Cambridge, Maryland 21613 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/22/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral 22. Name and Address of Fecility Witzke Funeral Homes, Inc. 21. Signeture of Funeral Service Licensee 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finel Cerebro Unsev/nn disease or condition resulting in deeth) Examiner Physician/Medical Examiner physician and s the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of Box 68760. Due to (or as a consequence of): P.O. | Part II. Other eigniticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, Be Completed by by soidisn 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? Affective Disorder 25. Was cese referred to medical examiner? 200 No 1 Yes No Division of Vital 26. Piece of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Aursing Home 5 Residence 6 Other (Specify) rai Director: After this c Certification: To 27. Manner of Death 28a. Dete of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attanding 5 Pending investigation Natural 2 Accident 1 Yes 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital of within 24 hours e' To the Funeral D completely filled Descertifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and menner es steted.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) 1613 302 CUllING MichAe ndden MD 31. Date filed (Month, Day, Yeer) 32. Registrar's Signature State 9 Registrar

DHMH 16 Bay 6/95



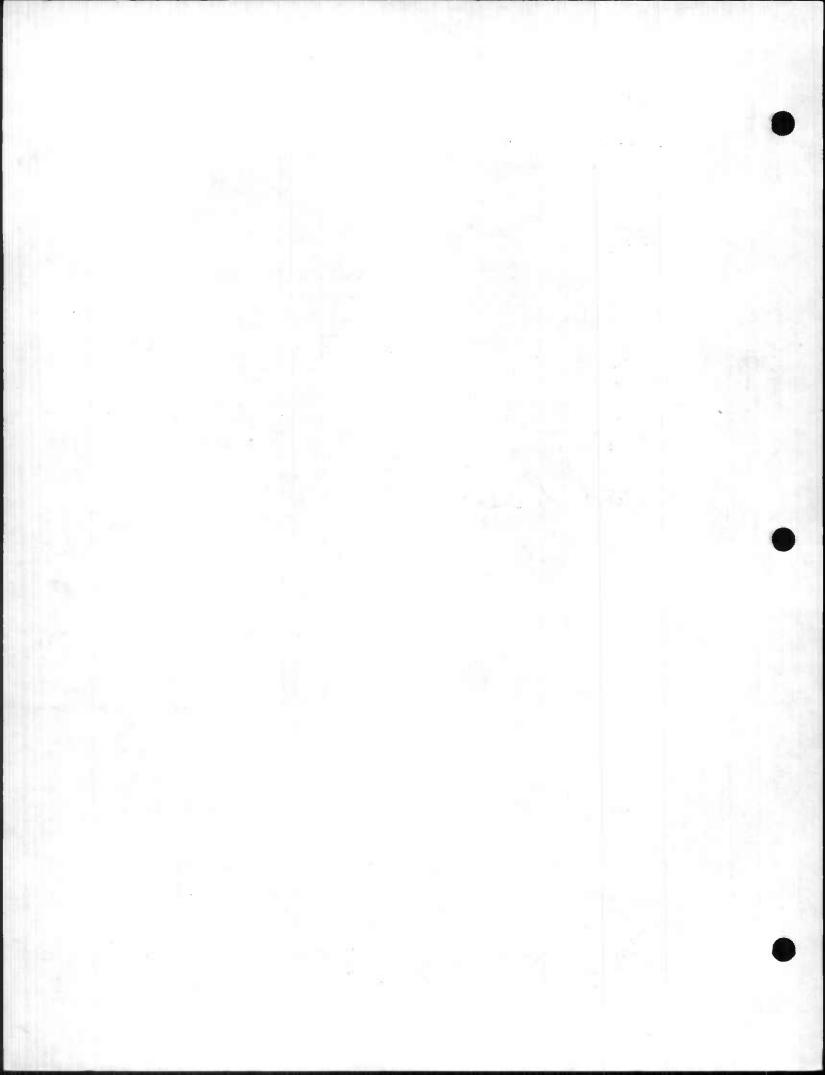
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Bea No 9 9 1 8 9 7

				Cei	rtificate c	of Death		leg. No. 9 9	U	39/1				
		1. Decedent's Neme (First, Middle,	Last)				2. Dete of Dec	oth Day	Year	3. Time of Death				
	ysician fedical	Paul Anton O	Lsen				March 1		1999	12:15 A.				
100	aminer	4a Facility Nama (If not institution,	nive street and number)			4b. City, Town, o	or Location of Death	4c. County	of Deeth					
		Spa Creek Nursi	ng Center			Annapo		Anne	Arund	ie1				
Fune Direc		5. Sociel Security Number 207 18 6809	Sex 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	s. last birthday) Yrs.	Months Da		in. (Month, De	, Year) 30, 1925		lace (State or Foreig try) rway				
р,	100	Usuef Residence of Decedent 10a. Stete 10b. County	100	City, Town or Lo	antina					ad tasks Ob. Had				
e Maryla	ctor			owie	Callon .					0d. Inside City Limit: 12□XYes 2□ No				
th with th	al Director	10e. Street and Number 12707 Buckingha	m Drive		10f. Zip Cod	20715		10g. Citizen of 1 United						
21215-0020 d within 72 hours after death with the Maryland giene. r than "natural", or flema 23s or 28s-f show	Examiner must	11. Meritel Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1. ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 4 1 —		Was Decedent of Yes, specify C	Suban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		ce - America ck, White, e y: Whi	etc.				
5-0 72 ho	te per	15. Decedent's (Specify only highest	Education	16a. Dece	dent's Usual Oc	cupation ne during most of v	endring .	16b. Kind of B	usinass/ind	s/Industry				
within and	Completed	Elemantary/Secondary (0-12)	College (1-4or 5+)	life.	rance A	ion in in in in in in in in in in in in in	Insura	ance						
A DOF	B S	17. Father's Name (First, Middle, La	st)	11130	Tunec 1	18. Mother's N	lama (First, Middla, Ericksen	Maidan Suman	ne)					
	traumatic	19e. Informent's Neme/Reletionship	(Type, Print) Wife				Aural Aouta Numbe Lve Bowie							
0 802	or other	20a. Method of Disposition 1 Burial 2 Cremetion 3	□Removel from State	Place of Dispo cemetery, crea	osition (Nama or matory or other	place) March	16, Dele 1999	20c. Location	- City or Tox	wn, State				
Saltim emit. Peg separtment mportant: I	Š	4 Donetion 5 Other (Spe				ematory		Alexa	ndria	Virginia				
Depart Depart	any ing	21. Signature of Funaral Service Lic	Li Oler	R	obert E		Funeral Ho Rd. Bowie			715				
Physic	ian	23a. Pert1. Enter the disaese, or co shock, or haart failure. List or	mplications that caused the de ly one cause on each line.							Approximete Interval Between Onset and Deeth				
/Medi Exami	ical	Immediate Causa (Final disease or condition resulting in deeth) a. Arteris clerk heart disease												
		resulting in deetily	Due to	(or as a consec	quence of):									
be :	aline		bC	a-dive	my 400	lly .			1					
an and	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	immediate											
Gox 68 / 60, death certificate be executed e attending physician and	2	that initieted events resulting in death) Last	C. Due to	(or as a conseq	juence of):									
	Physician/	Pert II. Other afgniffcant conditions	Pert II. Other afgniffcant conditions contributing to death but not resulting in the underlying cause given in Part I.					obacco una co	entribute to	the cause of deati				
requires that the del	be detach						10	1 Yea 2 No 3 Probably 4 White						
aw requ	piete							performed? eveilable prior		mpletion of causa				
The lay	Com						101	es 2 No	10	Yes 2□ No				
Iclan: The	Be (25. Was case referred to medical axaminer?				26. Place of C	Death (Check only o	na)						
Physician:	ē 2	1 Yes 2 940	Hospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3D DOA	Other: 4 Nursing	Homa 5 ☐ Resid	lence 6 Oth	ner (Specify)				
Attending Pr or death.		27. Manner of Death 1 Netural 5 Pending 2 Accident investigat	28a. Data of Injury (Month, Day Year) ion	28b. Time of Injury		njuryat Nork? I∐Yes 2∐No	28d. Describe I	28d. Describe how injury occurred						
DIVISION or Attending after death. Director: After	led in by the funeral Certification:		3 ☐ Suicide 4 ☐ Homicide Could not be detarmined 28e. Place of tnjury - At homa, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)					
Hospital 24 hours Funeral	Medical Certifi	29a. Certifier Certifying (Check only one)	Physician: To the best of my kr aminer: On the basis of examinand manner stated.	nowledge, death nation and/or in	n occurred at the vestigation, in m	e time, data and pla ny opinion, death oc	ice, and dua to tha courred at tha time,	causa(s) and madata end place,	annar as st	ated. tha cause(s)				
To the Te the	₩ 2	29b. Signature end titla of partifier	0		29c. Lic	ense number		29d. Dete signe	d (Month, I	Day, Year)				
V	1	D 25. V.	SOLIL MD		Λ	32036		3/10	-195					
n	1	0 2	o completed cause of death (It	em 23a) (Type,		Cl.	L MI	3/15						
	State	31. Data filed (Month, Day, Year)	32. Registrar'a Sign	nature.	100	ou one	, m, 0 0	1 016	()					
Reg	State gistrar	MND 1 0 100	a ledwar	B	book	/								

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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Items: 10f,19b per F.H G-769 3/19/99 reb Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month 3. Time of Deeth Year **Physician** Mildred Oliver MARCH 1999 1905 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** Sinai Hospital Baltimore. Baltimore If Under 1 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Day, Yeer) **Funeral** Days Hours 10 M 20 F Yrs 61 219387171 April 11, 1937 Baltimore Hd Director Usual Residence of Decedent deeth with the Marylend permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show any highry or other traumatic event, the Wedcal Examinat must be notified anone. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Md Director NA Baltimore 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 21215 U.S.A Avenue 21205 3317 aton Funeral 14. Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Manital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yas 2 No Specify. Specify: Black altimore, Maryland 21215-0020 þ 3 ☐ Widowed 4 ☐ Divorcad Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Dacadent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Md General Elementary/Secondary (0-12) Collaga (1-4or 5+) 12th grade Dietary NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Malden Sumeme) Be OLiver Evelyn Leonard Lathan 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rurel Route Number, City or Town, Stete, Zip Code) Paton 31 Baltind ZIZOS amela Blackwell-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Baltimore Cenetary 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1arch F. H. West Ala 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Ba 140, Md 21215 wabash guenne Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final Metastatic cervical concer diseasa or condition rasulting in daath) Examiner Due to (or as a consequenca of): Examiner physician end s the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Entar Undarlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequença of) attending p ed by the al 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed t Bowel obstruction þ 24a. Was en autopsy 24b. Were autopsy findings available prior to Completed complation of causa of daath? ate hes t 1 Yes 2√No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: 24 hours after death. 25. Was casa raferrad to medical examinar? funeral director. Be 26. Place of Death (Check only one) Othar: 4 ☐ Nursing Home 5 ☐ Rasidanca 6 ☐ Other (Specify) 1√ Inpatiant 2 ER/Outpatient 3 DOA Certification: To this 28d. Dascribe how Injury occurred 27. Mangar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Panding Investigation 1 Natural after death. 1 ☐ Yas 2 ☐ No 2 Accident To the Hospital or Atterwithin 24 hours after ded To the Funeral Director completely filled in by the 3 ☐ Suicide 6 Could not be determined 281. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Medicai 29a. Cartifier 1 Certifying Phyalcian: To tha best of my knowledga, daath occurred at the time, date and placa, and due to the causa(s) and mannar es stated. (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and placa, and dua to the causa(s) and manner stated. 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Yeer) NBrathwaite, MD. Oblayn 2 ND yr 11224 March 16, 1999 30. Name and address of parson who complated causa of daath (Item 23a) (Type, Print) Natalie Brathwaite Sinai Hospital of Balhmore Baltmore, MD 21215

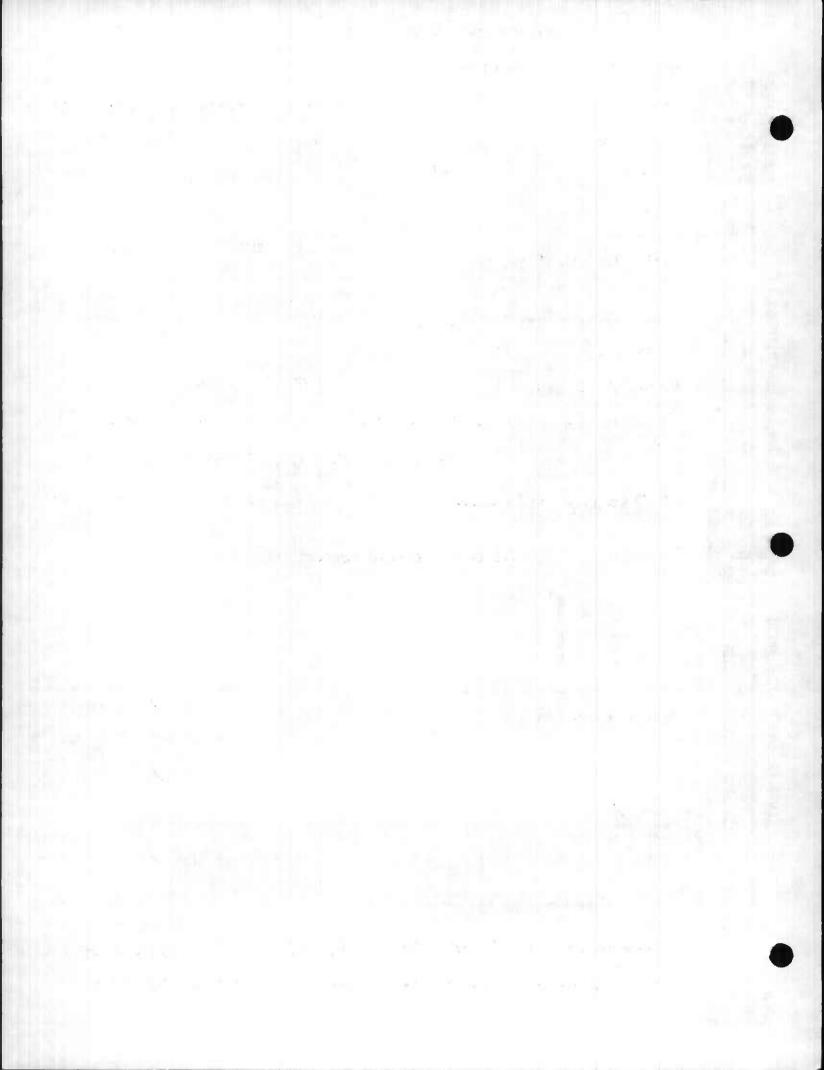
DHMH 16 Rev 6/95

Registrar

31. Date filed (Month, Day, Year)

MAR 1 9 1999

32. Ragistrar's Signatura



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedant's Nama (First, Middla, Last) Month **Physician** Edwin Oliver ar. 1999 5:30 AM /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner H Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | Country)

April 4, 1906 | Maryland Genesis Elder Care Brooklyn Park 5. Social Security Number 6. Sax 1 M 2 F 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Yrs. 705-03-6007 92 Director Usual Rasidence of Decedant death with the Maryland 10a Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits r 28a-f show Nas 2□No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? Pages 1 and 2 should be filed within 72 hours after death with neat of Hauth and Mental Hygiena.

int: if item 27 is marked other than "natural", or items 23a or intro yor other traumatic svent, the Medical Exprise man to a 21230 1627 S. Charles Street United States Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Detas: 13. Was Decedanf of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14 Race - Amarican Indien. Bleck, White, atc. 1 □ Never Merried 2 □ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: White Specify: þ 3 ☐ Widowad 4 N Divorced Completed 16a. Decedant's Usual Occupetion (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highest greda completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Lab Technician Chemical 17. Fefher's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maidan Sumame) Oliver Solomosy Bertha Triftling 19b. Malling Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Neme/Relationship (Type, Print) Eileen R. Schneider/daughter 822 S. Warwick Rd. Baltimore, Md. 21229 20a. Mathod of Disposition
1 ☑ Buriel 2 ☐ Cramation 3 ☐ Ramovel from State 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata permit. Page Department of Important: If any Injury or once. Loudon Park Cemetery 3/22/99 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Ambrose Funeral Home, Inc. Arbutus Maryland 21227 1328 Sulphur Spring Rd. 23a. Pert1. Enfar fhe disease, or complications that caused fhe deefh. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or haert feilura. List only ona causa on aach lina. Approximeta Intarvat Batween Onsef end Deeth **Physician** Lobe Pneumonia /Medical Immediata Causa (Final disaasa or condition rasuiting in daath) Examiner spiration Examiner physician and the burial-trans Sequantialty list conditions, if eny, leading to immadiata cause. Enter Underlying Causa (Disaasa or Injury that initiated available) Due to (or es e consaguança of): Division of Vital Records, P.O. Box 68760, Physician/Medicai that initiated avants rasulting in daath) Last Due to (or as e consequence of): 98 esn for signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yea 2 No 3 Probably 4 th tinknown 20 Congestive Heart Failure 24b. Wara autopsy tindings eveilable prior fo Completed 24a. Was an autopsy complation of cause of daeth? page 2 1 ☐ Yas 2 1 No 1 ☐ Yas 2 ☐ No or Attending Physician: funeral director, 25. Was casa refarred to medical axaminar? 26. Placa of Deeth (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yas 2 No After this 28a. Date of Injury (Month, Day Yaar) 27. Mennar of Death 28b Time of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? 5 Panding investigation 1 Neturel after death. Director: Aft 1 ☐ Yas 2 ☐ No 2 Accidant 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stete) 6 Could not be detarmined 3 ☐ Suicida 28e. Plece of Injury - At home, farm, straef, fectory, office building, atc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral C completaly filled 1 🖭 Certifying Physician: To tha bast of my knowladga, daath occurred at tha tima, deta and place, and dua to tha ceuse(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or trivastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature end fitla of certifiar 29c. Licanse number 0014 Mar. 18 1999 30. Nama and address of person who complated cause of death (Itam 23a) (Type, Print)

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State Registrar Ceci

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32. Registrar's Signature

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31. Datavilled (Month, Day, Year)

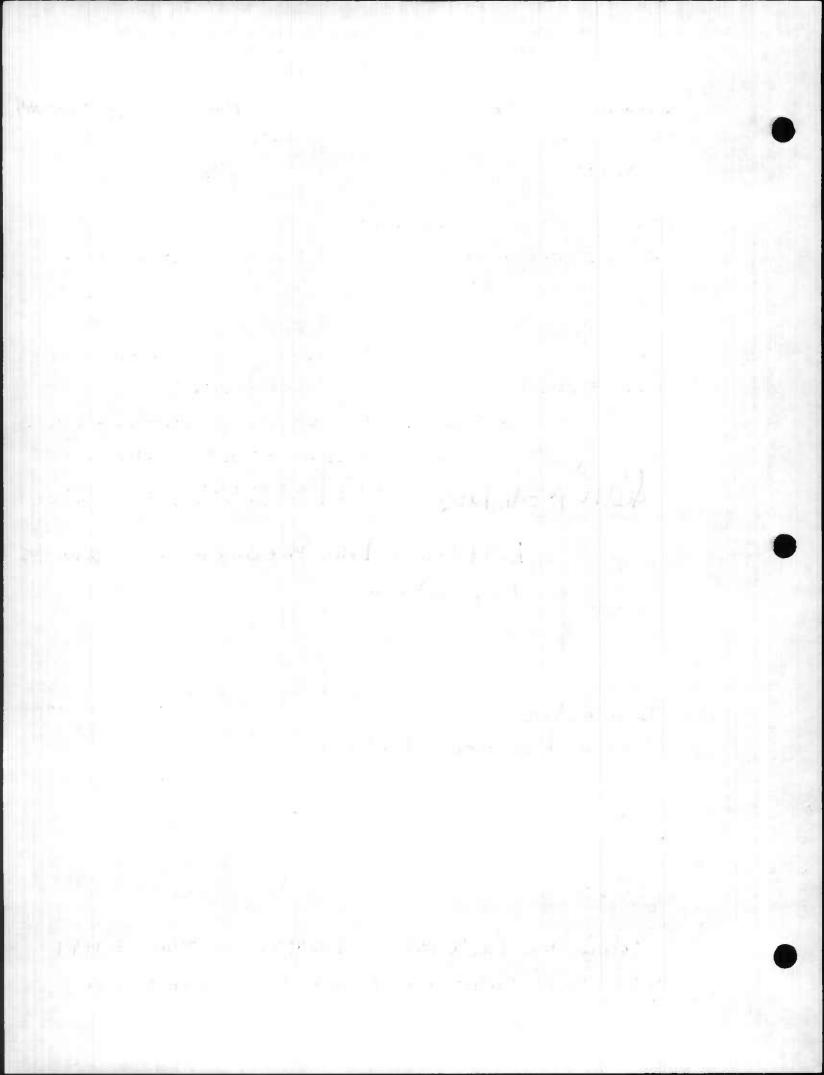
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State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician JAMES ONEILL 01:09 THOM AS MAB 18 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deel Examiner HOWARD HOSPITAL COLUMBIA HOWARD COUNTY GENERAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Dete of Birth (Month, Dey, Year) **Funeral** Days 10 M 2□ F Yrs. 213-34-4427 Director Maryland Usual Residence of Deced the Maryland 10d. Inside City Limits 10n State 10b. County 10c. City. Town or Location r than "natural", or itema 23a or 28a-f ahow the Medical Examinar must be notified at 1 Yes 2 No Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21043 U.S.A. 5249 Kerger Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Dependment of Health and Mental Hygiens.
Important: If Nem 27 is marked other than "instural", or hem apply Injury or other traumatic ayent, the second of the permits of the page. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify. by 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **Howard County** Dep. Chief, Bureau of Highways 12 17. Father's Name (First Middle Last) 18. Mother's Neme (First, Middle, Maiden Surneme) 8 Johanna Elizabeth Resch Herman Simon O'neill 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5249 Kerger Road Ellicott City, Maryland 21043 Wife Mrs. Joyce O'Neill 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removel from State 03/22/99 Marriottsville, Maryland Crest Lawn Memorial Gardens Moniture of Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 MC0533 Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Physician /Medical MYOCARDIM INFARCTION mmediate Cause (Final 30 min disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner CORONARY ATHEROSCLEROSIS 30 YEARS physician and the burlei-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of): 000 Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Pres 2 No 3 Probably 4 Unknown MELLITUS 1,4BETES à 24a. Wes en eutopsy performed? 24b. Were autopsy findings aveilable prior to Completed HYPERTENSION completion of cause of deeth? 1 Yes 2 No t Yes 20 No Division of Vital is after ding Physician: T s after deeth. Si Director: After this certificat ed in by the funeral director, p 25. Was case referred to medicat examiner? 8 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) in 24 hour. The Funerel Discrete Purchase In Discrete 4 Homicide edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated. 29a. Certifie To the Hosp within 24 hos To the Fune completaly fi 26/3 29b. Signature and tips of 29d. Date signed (Month, Day, Year) D37343 30. Name and address of person pleted cause of death (Item 23a) (Type, Print) HEIGHTS AVE. BAITMORE MD MORGAN MD, MHS. 2600 LIBERTY

Registrar DHMH 16 Rev 6/95

State

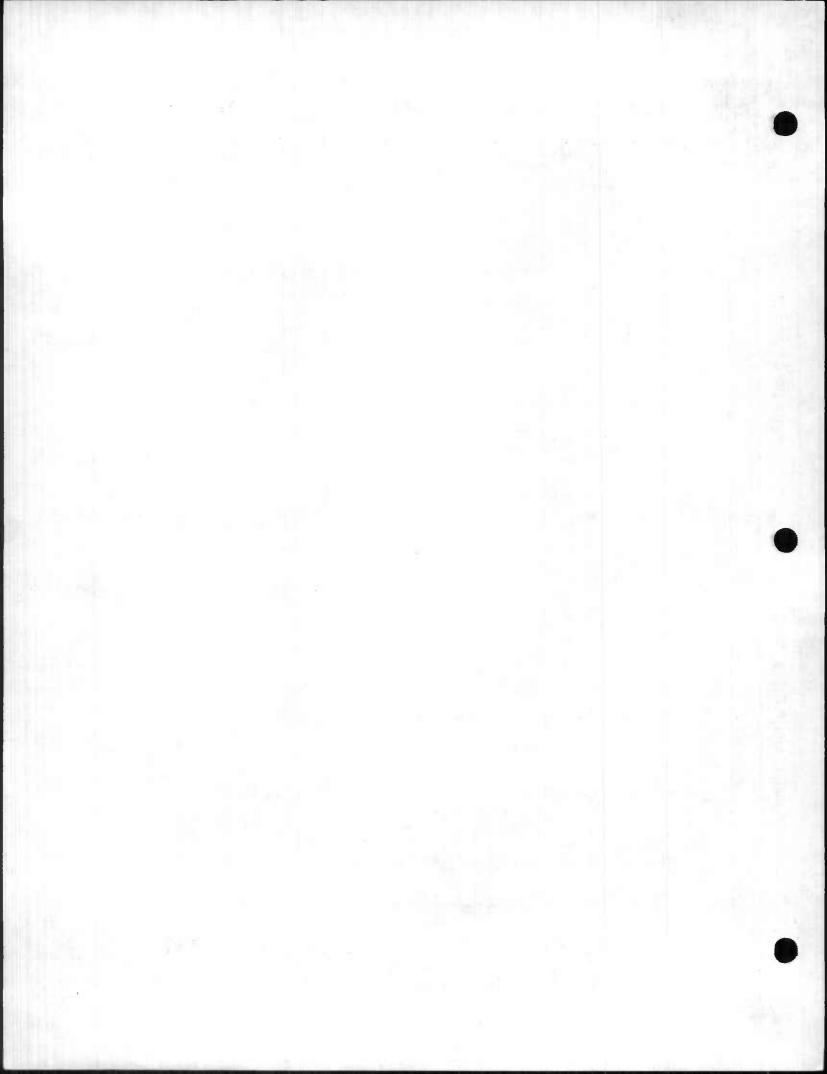
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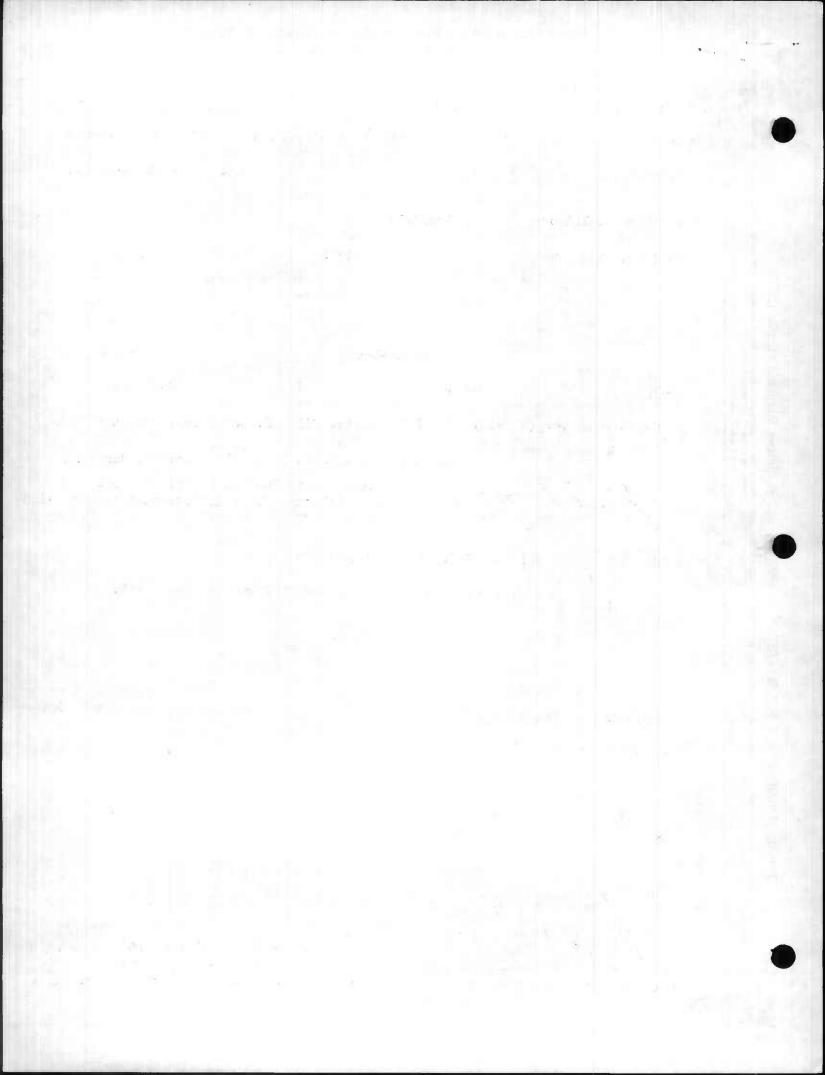
32. Registrar's Signature

General



State of Maryland / Department of Health and Mental Hygiene 9 08975

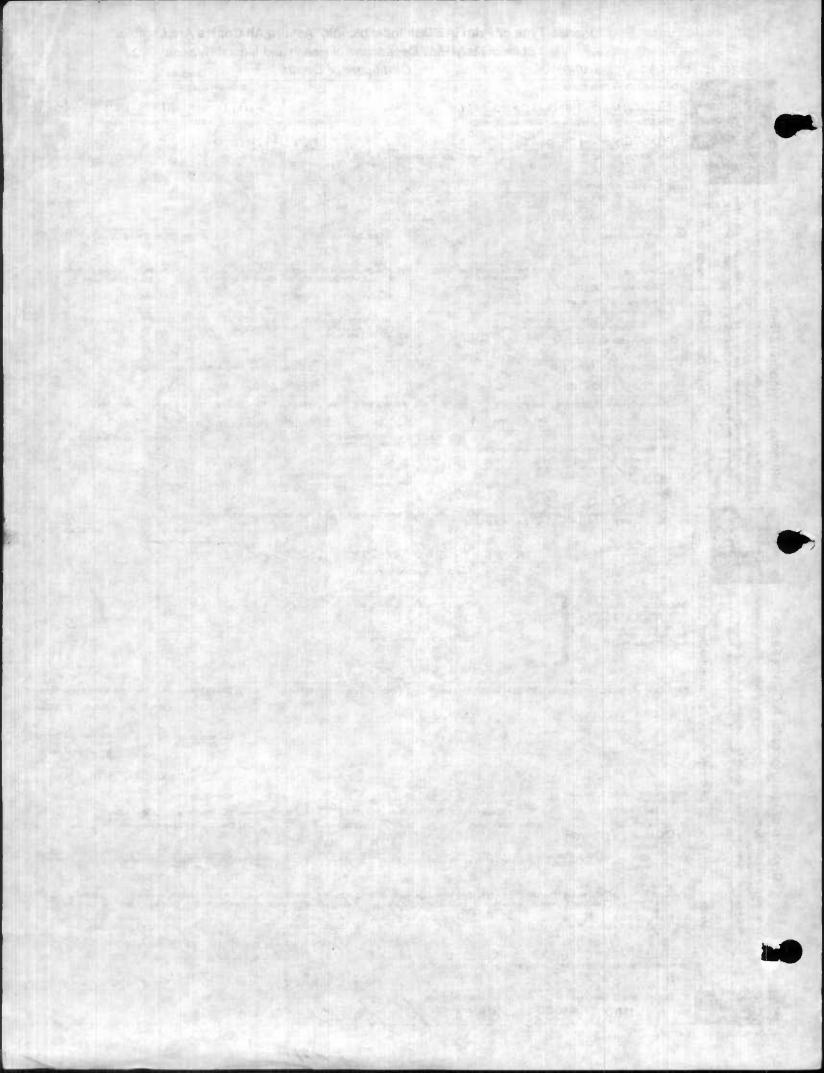
	Certificate of Death	F	leg. No.	00210					
Physician	1. Decedent's Name (First, Middle, Last) PAPE.	2. Date of Dea Month	Dey 14 Ye	3. Time of Dealt					
/Medical Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Town,	or Location of Death	4c. County of [
Funeral Director	214-07-7346 1 1 81 Yrs.	Irs. 8. Date of Birth in. (Month, Dey June 19	9. 1917 Ma	Birthplece (State or Fore Country) aryland					
show id at	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Lim					
be notified Director	Maryland Baltimore Rockdale		10- Oli 1140						
2 0	10e. Street and Number 10f. Zip Code 21244		10g. Citizen of Wha						
by Funeral	11. Maritel Stetus 1 Never Merried 2 Merried 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? If Yes, specify Cuben, Mexican, Put Yes, Give Year or Dates:	(Specify Yes or No- erto Rican, etc.)	Black, V	American Indian, White, etc. White					
Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of life. DO NOT use retired)	working	16b. Kind of Busin	ess/Industry					
mo	Elementary/Secondary (0-12) College (1-4or 5+) 7 Homemaker	1	Own 1	Home					
Bec	17. Father's Name (First, Middle, Last) 18. Mother's Pather's Name (First, Middle, Last)	Name (First, Middle,	Meiden Sumeme)						
0	Ira Helman Ida		Sullivan						
7	19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or	Rural Route Numbe	r, City or Town, Ste	ite, Zip Code)					
	Vanna G. Rehmeyer (cousin) 20a. Method of Disposition 1	Date	re, Maryl 20c. Location - City Laurel, M	y or Town, Stete					
8300	22. Name and Address of Facility Loring Byers Funeral Directors, 8728 Liberty Rd. Randallstown, 23a. Part. Enter the disease, or complication that bewed the death. Do not enter the mode of dying, such as cardiec or respiretory errest, all parts. Enter the disease, or complication that bewed the death. Do not enter the mode of dying, such as cardiec or respiretory errest, all parts. Enter the disease, or complication that bewed the death. Do not enter the mode of dying, such as cardiec or respiretory errest, all parts. Enter the disease, or complication that bewed the death. Do not enter the mode of dying, such as cardiec or respiretory errest, all parts. Enter the disease, or complication that bewed the death. Do not enter the mode of dying, such as cardiec or respiretory errest, all parts. Enter the disease, or complication that bewed the death.								
attending physician and for use as the bural-transit cian/Medical Examiner	disease or condition resulting in death) a. TULMONARY EMBOLISM Due to (or es e consequence of): BILATERAL DEEP VEIN THE Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	composis	07. 186	5.5					
hed for ysicia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did t	obacco use contri	bute to the cause of des					
y Phy	589813	101	Yes 2□ No 3	□ Probably 4 Unkn					
To Be Completed by Physician/	CLOSTRIDIUM DIFFICLE COLITIS	performed? eveilable completi		24b. Were autopsy finding eveilable prior to completion of cause of death?					
Con Con		101	res 2X No	1 ☐ Yes 2 ◯ No					
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To	1 Yes 20 No Hospital: 1 Unpatient 2 ER/Outpetient 3 DOA Other: 4 Nursin	g Home 5 ☐ Resid	dence 6 Other	(Specify)					
ed in by the tunera Certification:	27. Menner of Death 1 Netural 5 Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury et Work? 2 Accident 3 Suicide 6 Could not be 28a. Date of Injury 28b. Time of Injury 28c. Injury et Work? 1 Yes 2 No		now injury occurred	or Rural Route Number,					
	4 Homicide determined building, etc. (Specify)	City or Ton	vn, Stete)	or ridia, riddle ridinger,					
10 B	Certifying Physician: To the best of my knowledge, death occurred at the time, date and placed in the control of the basis of examination and/or investigation, in my opinion, death of and manner stated.	ccurred et the time,	date and place, end	due to the cause(s)					
To the comple	29b. Signature and title of certifier House PHYSICIAM 29c. License number 24272	3 m	29d. Date signed (I	1990					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3745 AVV ERAHALLT M LARISH BALTH	FOX FORD	MD	21236.					
State	31. Date filed (Month, Day, Yeer) 32. pegistrar's Signature	- 104-6							



State of Maryland / Department of Health and Mental Hygiene 0 0

ITEM: #1 PER MD G769 3-19-99 WR. Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** Month Payne, Frances PAYNE March 11:45 AM 1999 /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner H Under 1 Year H Under 24 Hrs. 8. Data of Birth (Month, Day, Year)
Hours Min. (Month, Day, Year) Mercy Hospital Batimore 5. Social Sacurity Number 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foreign Country) **Funeral** 1□M 2□F Yrs 218-03-9929 91 Director Sept. 02 1907 Maryland Usual Rasidanca of Dacedant 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 77 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examiner must be notified at Md. Balto. Co. 1 ☐ Yas 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 10 8050 E. Dale Road 21227 USA Funeral 12. Was Decedant Evar in U,S. Armed Forces? 14. Race - American Indian, Biack, Whita, atc. 13. Was Decadant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1 ☐ Yes 2 No If Yas, Giva Yaar or Datas: 1 Never Merried 2 Married 1 ☐ Yas 2 No Spacify: Specify: white þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry al Hygiene. Elamentery/Secondery (0-12) Coltege (1-4or 5+) Sale Clerk **Epsteins** 0 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maldan Surname) Be should be Is marked Thomas Morgan Isabella Fraizer 2 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stete, Zip Coda) permit. Pages 1 end 2 sh Department of Health and Important: If Item 27 Is m any Injury or other traum once. (Daughter) 8050 E. Dale Road, Baltimore, Md. 21227 Joyce Legg 20a. Mathod of Disposition 20b. Plece of Disposition (Nama of camatary, crematory or other place) 20c. Location - City or Town, Stata Date Burial 2 □ Cramation 3 □ Ramoval from State 4 □ Donation 5 □ Other (Spacify) Easton, Md. 3/20/99 Talbot Co. Windy Hill Cemetery 21. Signatura of Puneral Sarvica Licensee 22. Name and Addrass of Facility McCully-Polyniak Funeral Home P.A. long 130 E. Fort ave. Baltimore, Md. 21230 23a. Part1. Enter the disaasa, or complications that causad the death. Do not anter the mode of dying, such es cardiac or respiratory arrast, shock, or heart failure. List only one ceuse on each line. Approximeta Intervel Batween Onset end Deeth **Physiclan** Immediata Causa (Final disaasa or condition rasulting in death) /Medical Cerebrovascular accident Examiner Dua fo (or as a consaquance of) Examiner sician and buriel-trans Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consaguanca of) 68760 the attending physician hed for use as the burie Physician/Medical that initiated events resulting in deeth) Last Dua to (or as a consequence of): Box P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown artery disease Records. by 24b. Were eutopsy findings eveilabla prior to complation of causa of death? Completed 24a. Was an autopsy peen certificate has page 1□ Yas 2 No 1 Yas 2 No of Vital Be 25. Was casa rafarrad to medical 26. Plece of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospitat: 1 ★Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 1 ☐ Yas 2 No To After this 27. Manner of Death 28c. Injury et Work? 28b. Tima of 28d. Dascribe how Injury occurred Certification: Division Attending 1. Naturat 5 Pending investigation il or Attending s effer death. 1 ☐ Yas 2 ☐ No 2 Accidant 28f. Location (Straet and Number or Rural Routa Number, City or Town, Stete) 3 Suicida 6 Could not be datarminad 28e. Plece of Injury - At homa, farm, straet, factory, office building, atc. (Spacify) à 4 Homlcide To the Hospital
within 24 hours a
To the Funeral C
completely filled Certifying Physician: To the best of my knowledga, death occurred at tha tima, data end plece, and dua to tha ceuse(s) end mennar as steted.

2 Medical Examinar: On the bests of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and mannar stated. 29a. Cartifian Medical (Check only one) 29d. Data signad (Month, Day, Year) 29b. Signature and title of certifial 29c. Licansa numbar evener ms 30. Name and addrass of person who completed cause of death (Itam 23a) (Type, Print) Mercy Medical Center Baltmone, Maryland Clevenger nn 31. Dete fitad (Month, Day, Year) 32. Registrer's Signatura State Egrena MAR 1 9 1999 Registrar

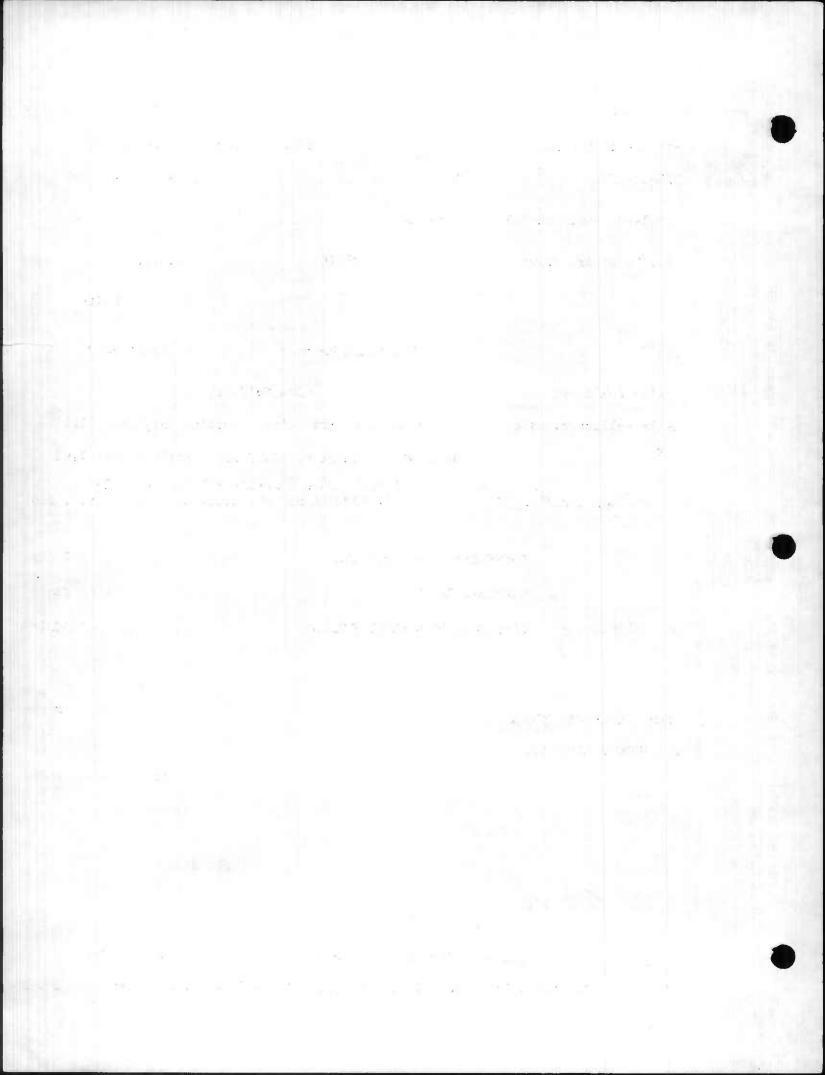


Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			· maryian		tificate of	Health and I	2. Date of De	Reg. No.	085)	
Physician /Medical	Decedent'a Nama (First, Middle, MAX	POLLIC	LLICOVE				Day 2. 1999	Year	Time of Deeth 1:36 PM		
Examiner	MAX M. POLLICOVE 4a Facility Name (If not institution, give street and number) 4b. City, Town, or						Location of Deat	h 4c. County	of Death		
	Holy Cross Hospi	tal				Silver S	nring	Mont	gomery		
uneral		S. Sex	7. Age (In yrs	. last birthday)	If Under 1 Yaa	r If Under 24 Hrs	8. Date of Bi	rth Veer)		(Stata or Foreig	
rector	578-16-1579	1 € M 2 □ F	80	Yrs.	Months Days	Hours Min.	July 1		New Yo		
nd at	Usual Residence of Decedent						nuly 1	, , , ,	A15- FL 4.50		
rector	10a. State 10b. County		10c. O	ity, Town or Loc	cation				tOd. Ir	nside City Limit	
ţ	Maryland Anne A	rundel	C	rofton					1	X Yes 2 □ N	
Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Co										
D	1662 Wilkshire I) witte			2111	/.		U.S.A.			
Funeral	11, Maritai Status	12. Was Deci	edent Ever in U	J,S. 13. W		Hispanic Origin? (S ban, Mexicen, Puer	pecify Yes or No		e - Americen In	idian,	
F	1 Nevar Married 2℃Marrie	Armed Fo		If	Yas, specify Cu	ban, Mexicen, Puer	to Ricen, etc.)	Blac	k, Whita, atc.		
2	3 ☐ Widowed 4 ☐ Divorced	tf Yes, Giv Year or D	/8	1	☐ Yes 2⊠No	Specify:		Specify	White		
8	15. Decedent's			16a. Deced	ent's Usual Occi	upation		16b. Kind of Bu	usiness/Industr	v	
Completed	(Specify only highast	grede completed)		(Give I	kind of work done ONOT use retir	e during most of wo	rking				
Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)		house M			Gian	t Food		
Ö	17. Father's Name (First, Middle, La	est)					me (First, Middle	, Maiden Sumer	ne)		
Be		17. I ather a Harrie (1773), Wilders, Lasty							,		
2	Philip Pollicove					Eva Go		-			
	19a. Informant's Name/Relationshi					et and Number or R					
	Leila Pollicove	Wife	lan.			re Drive,				.114	
	20a. Method of Disposition	□ □ Bomouel from	Ctoto		natory or other pi		Date	20c. Location ·			
	4 Donation 5 Other (Spe		Mt	. Leban	on Ceme	tery 3/05	/1999	Adelphi	, Maryl	and	
	100h -1	111	3	SZ Name and Address of Facility SZEIN HEBREW MEMORIAL FUNERAL HOME, INC.							
	232 CARROLL STREET, N.W., WASHINGT 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest,										
	23a. Part1. Enter to disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat										
	Immediate Cours /First										
	Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE Due to (or as a consequence of):									WEEK	
line	a Proper	b CARDI	OMYOPA	THY					2	YEARS	
Examiner	Sequentially list conditions, Due to (or as a consequence of):										
	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury	CARCI	NOMA O	F UNKNO	WN PRTM	ARY			4-5	MONTH	
dicai	that initiated events rasulting in death) Last	c. OHIO	ARCINOMA OF UNKNOWN PRIMARY Dua to (or es e consequence of): 4-5 MONTH								
•	raconing in coalin, cast										
Physician/M		d	0.								
Cia	Part II. Other significent condition	s contributing to de	eath but not re	sulting in the un	derlying cause o	niven in Part I	23b. Did	tobacco uee co	ntribute to the	cause of dee	
hys	Takin dila agimooni dondidon	o contributing to co	Satir Bat Hot To	Sound III are on	loonying occure s	growth the date to		Yes 2□ No			
7	SMALL CELL CAR	CINOMA						7100 2010	0_1,0000,	y 424 Oman	
d by							24a. Wa	s an autopsy	24b. Were a	utopsy finding	
ete	NON HODGES LYMPI	HOMA					performed?		comple	available prior to completion of ceuse	
Completed									ot death?		
ပ္ပ							10	Yes 2XXXIII	1 ☐ Ye	s 2 No	
Be	25. Was cese referred to medicel examiner?						ath (Check only	one)			
2	1 ☐ Yes 2 ☒ No			ER/Outpatient	1 3LI DON			idence 8 Oth			
	27. Manner of Death 1 ⊠Naturat 5 □ Panding	28a. Date (Mon	of tnjury th, Dey Year)	28b. Time of Injury	28c. Inj	ury at ork?	28d. Describe	how injury occur	red		
Certification:	2 ☐ Accident investiga	tion				☐ Yes 2 ☐ No					
III	3 ☐ Suicide 6 ☐ Could no determin	208. PIECE	of Injury - At I	nome, farm, stra	et, factory, office	8		(Straet and Numb	per or Rural Ro	ute Number,	
en	4 Hornidae	Dulla	ng, etc. (Speci	ny)			Only or 1	, oraco,			
	29a. Certifier 1 Certifying	Physicien: To the	best of my kn	owledge, death	occurred at the	time, date and place	e, and due to the	cause(s) and ma	anner as stated	1.	
edicai	(Check only 2 Medical Ex	caminer: On the b	asis of examination	ation and/or inv	estigation, In my	opinion, death occi	urred at the time	, date and place,	and due to the	cause(s)	
Me	29b. Signatura and title of certifier		0		29c. Lice	nse number		29d. Date signe	d (Month, Day,	Year)	
	4	10 /	/	11							
	fund.	11/2	mel	1 mo	D35	996		March 3	, 1999		
	30. Name and address of person w										
	Linda Burrell,	M.D., 210)1 Medi	cal Par	k Drive	, #210, S	Silver S	pring, M	laryland	2090	
tate	31. Date filed (Month, Dey, Year)		legistrar's Sign	nature							

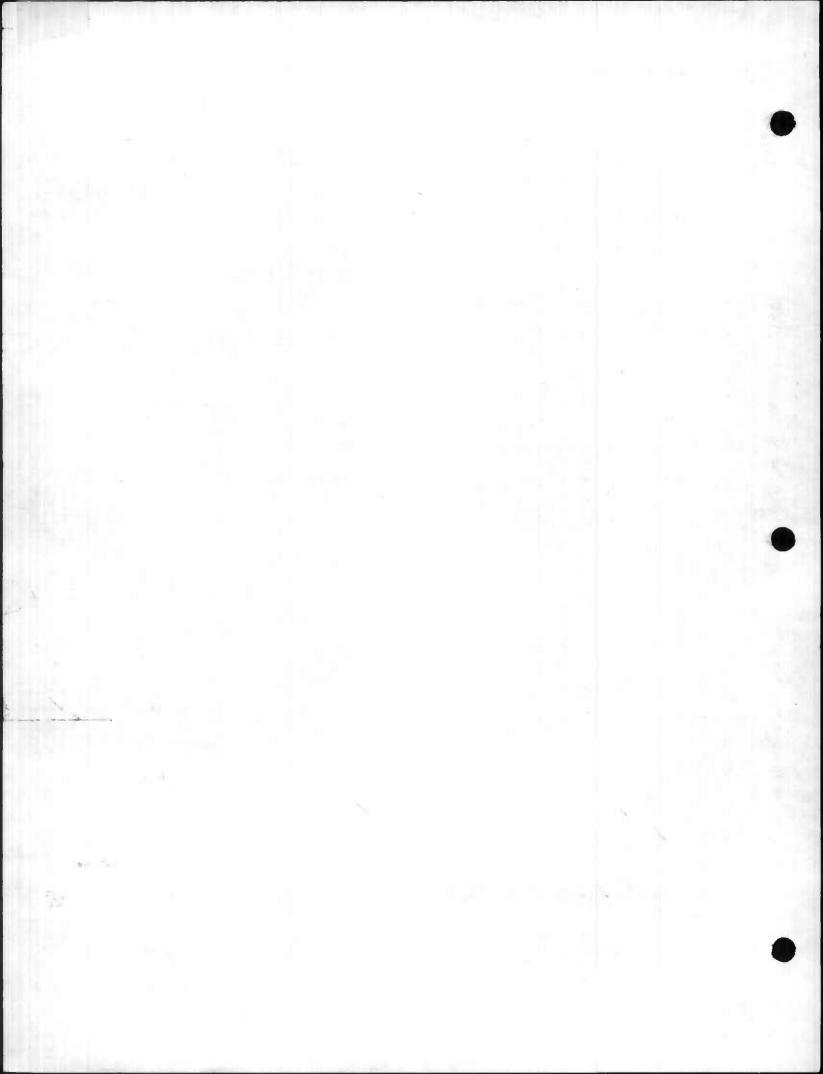
State Registrar

DHMH 16 Rev 6/95



ITEM: #2	5 PER MD G769 3-19-99 WR		Certificate			ene g. No. 9 9	08978		
Physician /Medical	Decedent's Nama (First, Middle, Las Mary Just 4a Facility Nema (If not Institution, give	nita Pari		bruary 27, 1999 930 AM					
Examiner	4a Facility Nema (If not Institution, give			4b. City, Town, or L. Baltsu		4c. County of Daltim			
Funeral Director	231 24 0720	9x 7. Age (In yrs. A ☐ M 2只 F 74	Yrs. If Under 1 Your Months De	ear If Under 24 Hrs. Ays Hours Min.	8. Date of Birth (Month, Day, 1 Aug. 10	(ear) 9.	Birthplaca (State or Foreign Country) Maryland		
ehow day	Usual Residence of Decedent 10a. State 10b. County		, Town or Location				10d. Inside City Limits		
the M 28a-f noting	Maryland Baltim 10e. Street and Number	ore City Ba	ltimore 10f. Zip Coo	le .	100	g. Citizen of Whe	1 Ves 2 No t Country?		
23a or	2813 Louise Aver	nue	212	214		U.S.A.			
P 28 P	11. Maritel Status 1 ☐ Never Married 2 ☑ Merried 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U,\$ Armed Forcas? 1 ☐ Yes, 2 ☑ No If Yes, Giva Year or Detes:	13. Wes Decedent II Yes, specify (of Hispanic Origin? (Sp Cuban, Mexican, Puerto No Specify:	pecify Yas or No- Prican, etc.)		Amarican Indian, White, etc. White		
L L L I 3-UUCU led within 72 hours at tygiene. Nor than "natural", or it, ins Wed cell Even Completed by I	15. Decedent's Ed (Specify only highest great Elementery/Secondery (0-12)	Education grede completed) College (1-4or 5+) 16a. Decedent's Usuel Occupation (Give kind of work done during most of work life. DO NOT use retired)				8b. Kind of Busin	ess/industry		
be file dothe event.	12 17. Father's Neme (First, Middle, Last) Willie Earl Osbor	ne 0	Manag	18. Mother's Nem	d Osborne	aiden Sumeme)			
2 shou and M la mark	19e. Informent's Neme/Reletionship (7	ype, Print)				nber, City or Town, Stete, Zip Code)			
IOCE, Marylis ges 1 and 2 should the Health and Mer If item 27 is marke or other traumatic	William Parkhill/ 20a. Method of Disposition	20b. PI	2813 Louise ace of Disposition (Name of metery, cremetory or other	1		Maryland Oc. Location - City			
Balfilmore, N bemit. Pages 1 and Department of Health mportant: If Item 27 nny injury or other 12	1 Buriel 2 Cremation 3 4 Donetion 5 Other (Specify	Hemoval from State	plece)						
Dearth Page Department of Important: If any injury or once.	21. Signatura of Finaral Service Licens Ronald S	d, 655 W. d 21201	. Baltim	ore Street					
certificate be assected and indirected by the burishment and use as the burishment and indirected Examiner	Immediata Ceuse (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	es a consequence of): alla consequence of): es e consequence of):	y di	seese				
Clarific att		d							
Dry the datached	Part II. Other eignificant conditions co	ntributing to death but not resu	lting in the underlying cause	given in Pert I.	1110 ACC 1003	ecco use contril	bute to the cause of death? ☐ Probably 4 ☑ Unknown		
s been s 2 should				444.7	24a. Wes an performe		4b. Were autopsy lindings available prior to completion of cause of death?		
					1 ☐ Yes	2 No	1 ☐ Yes 2 ☐ No		
Physician: The Physician: The rai director, pag.: To Be Co.	25. Wes case referred to medical examiner?	Hospitel:	EVOLUTION 3 DOA	Other:	th (Check only one		Sanath I		
Attending Physic or death. ector: After this ce by the funeral dire	27. Menner of Death 1 Menetural 5 Pending 2 Accident investigation		28b. Time of lanjury 28c. I	Injury at Work?		thow injury occurred			
2 5 4 5 E	3 Suicide 6 Could not be determined	28e. Pleca of Injury - At hor building, etc. (Specify,	ne, farm, street, lectory, off	ice	28f. Location (Stre City or Town,	eet end Number o State)	or Rural Route Number,		
To the Hospital within 24 hours of the Funeral Completaly filled	29e. Certifier 1 Certifying Phy one) 2 Medical Exami	sician: To the best of my know ner: On the basis of examineti end menner steted.	dedge, death occurred at the on end/or investigation, in n	e time, date end place, ny opinion, deeth occur	and due to the cau red et the time, dat	use(s) end manne e end plece, and	or as stated. due to the cause(s)		
To the compl	29b. Signature and little of certifier	-: (ense number	290	d. Date signed (A	fonth, Day, Year)		
	mu.	mes.	luo D.	29403		3/4/	99		
	30. Name and address of person who of CYNTHIA M.			YORK RJ.	Cutho	eville, 1	EP015 OM		
State Registrar	31. Date liled (Month, Dey, Year) MAR 1 9 19	32. Registrar's Signet	b. Los	2001					

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Year Month 3:30 pm Doris Parks 3 17 1999 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 2217 E. Chase Street Baltimore If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month) Days Hours Min. 9-28-1927 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 F 218-88-7880 71 Yrs. Md Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Md N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2217 E. Chase Street 21213 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married **Black** 1 ☐ Yes 2X No Specify: Specify: 3XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Post Office Elementary/Secondery (0-12) College (1-4or 5+) 12th grade N/A Stock Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Otis Noble Dorothy King 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Parks - Daughter E. Chase Street Baltimore, Md 21213 20b. Plece of Disposition (Neme of cemetery, cremetery or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete King Memorial Park 3-22-99 Randallstown, Md 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fedility March F/H West 21. Signature of Funerel Service Licensee 23e. Pert1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Baltimore, Md 21215 Approximete Interval Between Onset and Deeth Immediate Cause (Finel letastatic Lun Carce disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to 24a. Was an autopsy performed? completion of cause of death? 1 □ Yes 200 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Examiner physician and s the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, signed by t or vital

Vin 24 hours after death.

No 24 hours after death.

Ne Funeral Director: After this lieuwy filled in house. confilicate

Physician /Medical

Examiner

Physician/Medicai þ Completed Be

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan. Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f show with Injury or other traumatic event, the Mexical Emotine must be notified at page.

Baltimore, Maryland 21215-0020

Certification: To

edical

2 Accident 3 Suicide 4 Homicide 29a. Certifier

6 ☐ Could not be

28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) end manner stated.

(Check only one) 29b. Signature and title of certifier

29c. License number RES-0001 29d. Date signed (Month, Day, Year)

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 600 N. Wolf St. Tour-100, Baltimor MO 21297

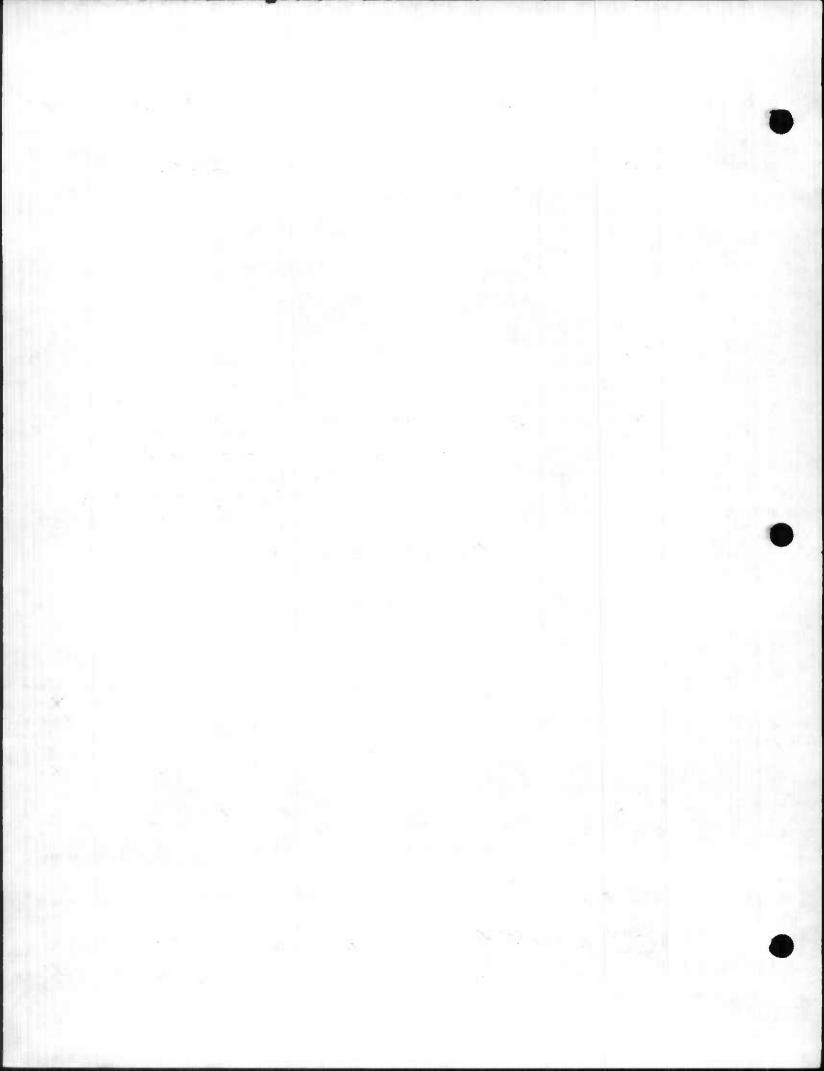
M.D. 1810 Drake

Track M.D/PhD

State Registrar

32. Registrar's Signeture

To the P



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Day Yaar 1:40 Pm 4c. County of Death 4a Facility Nama (If not ipstitution, giva street and number) 4b. City. Town, or Location of Death Balto nest d 212 CROU Road If Under 1 Yaar | If Under 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1□M 20 F Yrs. 118-20-4522 Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yas 2 No Ma 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code 21244 U.S.A 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-ff Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 Navar Married 2 Married 1 Yas 2 No Specity: Black 1 Yas 2 No Specify: 3 ☑ Widowad 4 ☐ Divorced Yaar or Datas: 15. Decedant's Education (Spacify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School ateteria 7th grade orthe NA 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Stringfield Ka che enry Hennell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Son 12a140 hesterton Harry 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Date 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) shell Memorial Park ature of Funeral Service Li 22. Nama and Addrass of Facility F. H · U wabash Grenne 23a. Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Immediata Causa (Final disaase or condition rasulting in death) RW Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Dua to (or as a consequence of) Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 Tyas 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Stata

Director

Funeral

p

Be Completed

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Menlel by Important: if item 27 is marked oth-any injury or other traumatic event page.

Pages 1 and 2 should be filed within 72 hours efter

Baltimore, Maryland 21215-0020

Examine

Physician/Medicai edical Certification: To Be Completed by

physicien end the burial-transit The lew requires that the death certificate be axecuted for use or Attending Physician: this After 24 hours after death. Funeral Director: A 2 filled in Hospital

Division of Vital Records, P.O. Box 68760

25. Was casa referred to medical axaminar? 1 Yas 2 No 27. Mannar of Death

29a. Cartifier (Check only

1 Natural 2 Accident 3 Suicida 4 Homicida

5 Pending invastigation 6 ☐ Could not be

Hospital: 1 Inpatient 2 ER/Outpatient 28a. Data of fnjury (Month, Day Year)

28b. Tima of Injury

3□ DOA

28c. Injury at Work? 1 Yes 2 No 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 28d. Dascribe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29b. Signature and title of Certifies

29c. Licansa number

Monument

1 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated.

29d. Data signad (Month, Day, Year)

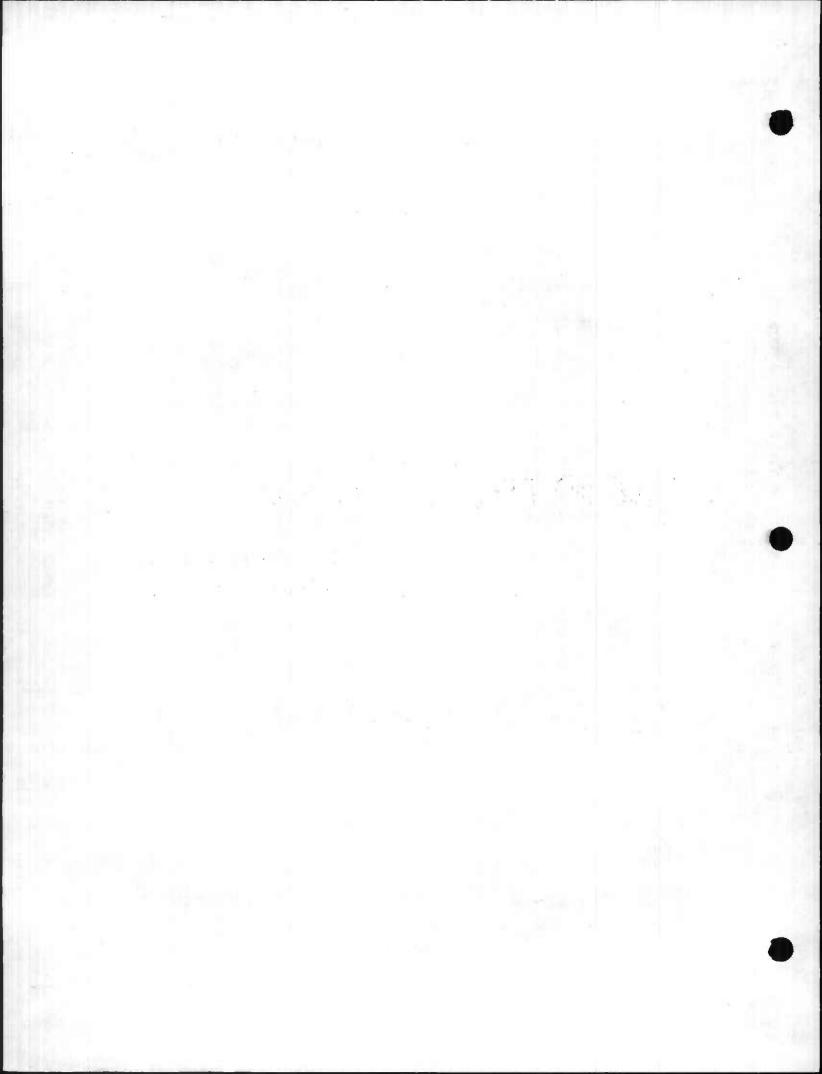
so Name and address of person who complated cause of death (Itam 23a) (Type, Print)

31. Data filad (Month, Day, Year) MAR 1 9 1999 ROSLE 22. Ragistrar's Signatura

State

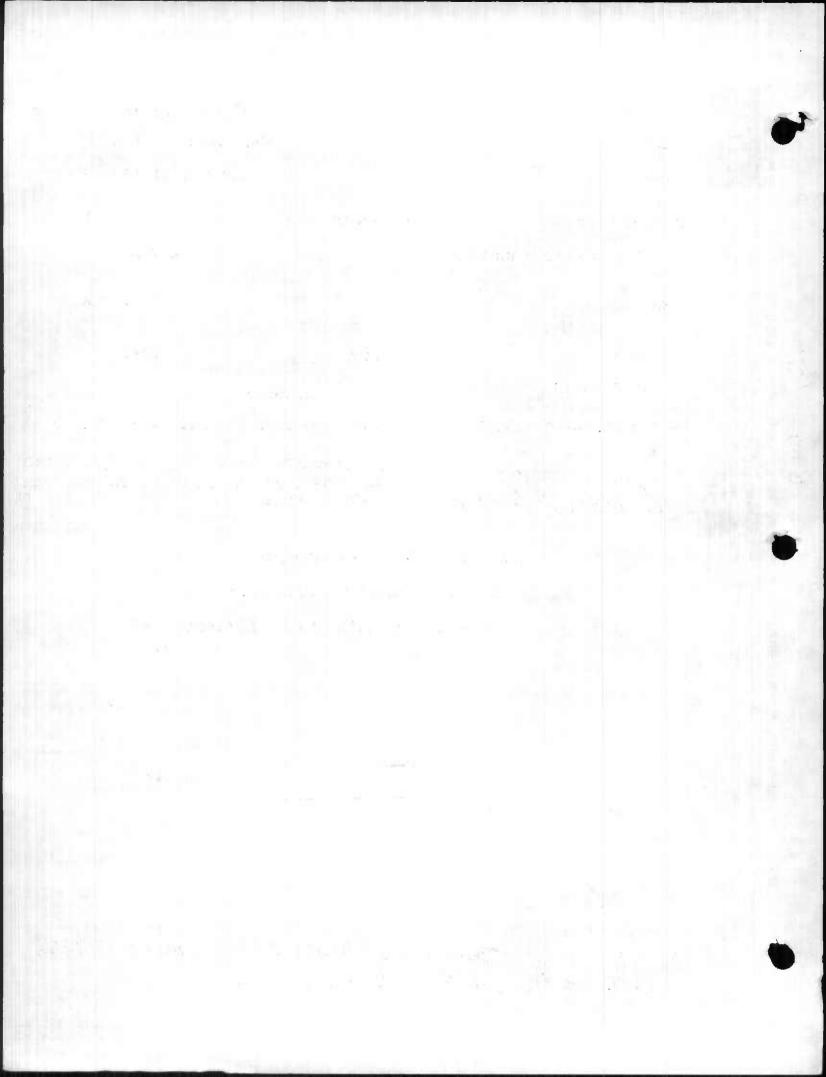
Registrar

To the P



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Tima of Death **Physician** 1999 GARY RAGIN Karch /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY N/A BON SECOUR If Under 1 Yeer If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Ye SEPT 28 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Year) Country) 8 1918SOUTH CAROLIN Months 1 X X 2 F 80 Yrs. 250-05-4502 Director Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 7 is merked other than "natural", or items 23s or 28s-f show traumatic event, the Massical Examiner must be notified at XIX Yes 2 No MARYLAND N/A BALTIMORE CITY Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 2231 W BALTIMORE STREET U.S.A. Funeral 12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: Was Decadent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 AND Specify: Maryland 21215-0020 Specify: BLACK þ 3 Widowed 4 □ Divorcad Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Flementary/Secondary (0-12) College (1-4or 5+) PRESSTMAN RUBBER 8th grade 18. Mother's Name (First, Middle, Meiden Surname) 17. Fether's Neme (First, Middle, Last) h and Mental I JUNE RAGIN unknown 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21229 19a. Informent's Name/Relationship (Type, Print) parmit. Pages 1 and 2 st Department of Health an Important: If Item 27 is n GRACE BUFFALOU/SISTER IN LAW 4313 Flowerton Rd. Baltimore Maryland 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 XBuriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) WOODLAWN CEMETERY 3 - 20BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensii WILLIAM C BROWN COMMUNITY FUNERAL HOME 1206 W. NORTH PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final MASSIVE GI BLEEDING disease or condition resulting in death) Examiner Examiner PEPTIL ULCER PISEASE ettending physician end for use as the buriel-transit that the death certificate be executed Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury CHRONIC OPSTRUCTIVE PULMONARY Box 68760. Physician/Medical that initiated events resulting in deeth) Lest DISEAPE SB use signed by the e 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings evailable prior to should Completed 24a. Was an autopsy performed? peed completion of cause of death? we page 2 Sec The 1 Yes 2 No 1 Tyes 2 No certificate Physician: 25. Was case referred to medicel examiner? Be 26. Plece of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Attending 1 Natural 5 Pending Investigation death. 1 | Yes 2 | No Director: A in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 24 hours efter
 Funeral Dire
letely filled in b ò 29a. Certifier Certifying Phyalcian: To the best of my knowledge, death occurred et the time, date and piece, and due to the cause(s) and manner as stated. edical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner stated. (Check anly one) within 2 290. Signature applitte of 29d. Date signed (Month, Day, Year) 29c. License number March 17, Dungea, M.D 30. Name and all releted cause of death (Item 23a) (Type, Print) North ayson 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 9 1999 Registrar

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month :00 AM 4b. City, Town, or Location of Death 999 4a Facility Name (If not institution, give street and number) 4c. County of Death Cherrywood Health Care Reisterstown Baltimore If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number Date of Birth Month, Day, Year) Dec. 23, 1918 9. Birthplace (State or Foreign Country) Bermuda 7. Age (In yrs. last birthday) 1□M 2 F Days Months 80 220-28-9138 Dec. Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Maryland Reisterstown 10e. Street and Number 10f, Zip Code 10g. Citizen of Whet Country? 5 Folly Farm Ct. 21136 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. Armed Forces? Race - American Indian, Bleck, White, etc. 11. Merital Stetus 1 ☐ Yes 2 1 No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Practical Nurse Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) John Aubrey Otto Myer 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Woodard A. Roberts - husband 5 Folly Farm Ct. Reisterstown, Md. 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Evergreen Mem. Gardens March 20, 1999 Finksburg, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel 11605 Reisterstown Rd. Owings Mills, Md. 21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Death Polmonal Immediate Cause (Final disease or condition resulting in death) Due to (or as e consequenca ot): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or es a consequence ot): Due to (or es e consequence of)

Physician /Medical Examiner

ettending physician and for use as the bunel-tran

signed by t

peed paga 2 s certificata

Mospital or Attending Physician: 7
24 hours after death.
 Funeral Director: After this certifica letaly filled in by the funeral director, p

within 2

The law requires that the death certificate be exacuted

Records, P.O. Box 68760,

Division of Vital

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be nother at

with the Marylend

death

filed within 72 hours after

Hygiena.

permit. Pages 1 and 2 should be filed will Department of Haalth and Mental Hyglen, Important: if tem 27 is marked other that any Injury or other traumatic event, that page.

Baltimore, Maryland 21215-0020

Examiner Physician/Medical Be Completed by Certification: To

Medical

Pert II. Other significant conditions		RUSTA	Jes a	23b. Did tobacco use co	antribute to the cause of death					
	J			24a. Wes en eutopsy performed?	24b. Were eutopsy tindings available prior to completion of cause of death?					
25. Was case referred to medical examiner?	26. Place of Death (Check only one)									
1 Yes 2 No	Hospitel: 1 Inpatient 2	☐ER/Outpatient 3☐ [OOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Ott	ner (Specify)					
27. Menne of Death 1 Natural 5 Pending 2 Accident investigation	28e. Dete ot Injury (Month, Dey Year)	28b. Time ot Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occur	1-1-1-17					
3 Suicide 6 Could not to determined		nome, farm, street, factorify)	28t. Location (Street and Number or Rural Route Number, City or Town, State)							

29c. License number

29d. Date signed (Month, Day, Year)

Registrar

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31. Dete tiled (Month, Day, Year) State

29b. Signature

30. Name and sddi

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ass of person wh

MO 32. Begistrer's Signature

mpleted cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Pierson Tuttle Raynor March 17 1999 4:30 am. /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Cherrywood Health Care Reisterstown Baltimore 8. Date of Birth (Month, Day, Year) March 7, 1912 9. Birthplace (State or Foreign Country) New York 6. Sex 1 M M 2 □ F If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 87 111-10-5462 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow treumetic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore Reisterstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 23 Glyndon Dr. 21136 U.S.A. Herns 23a deeth 12. Was Decedent Ever in U,S. Amed Forces? 1 ☐ Yes 2 ☐ No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Heelth and Mentel Hygiena. Important: if flem 27 la marked other than "natural", or the eny injury or other treumatic event, tre Medical Examinations. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: by White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerical Worker Dietrich Brothers 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elijah Raynor Blanche Learie 19a. Intormant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Anna Raynor - wife 23 Glyndon Dr. Reisterstown, Md. 21136 Baitimore. 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory March 18, 1999 Baltimore, Md. 22. Nama and Address of Facility
Eckhardt Funeral Chapel 21. Signature of Funeral Service Licenses 11605 Reisterstown Rd. Owings Mills, Md.21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner to (or as a consequence of) Examine physician and the burial-transit that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) for use as ned by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed t þ The lew requires 24b. Were autopsy findings available prior to should s Completed 24a. Was an autopsy performed? completion of cause of death? pege 2 s hes 1 ☐ Yes 2 EXNo 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1□ Yes 2□ No Other: 42 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28b. Tima of Injury 28d. Describe how injury occurred 28c. Injury at Work? After 1 ☑ Naturel 2 ☐ Accident or Attending 5 Pending investigation r death. 1 Yes 2 No Director: A 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) To the Hospital or Att within 24 hours stier of To the Funeral Direct completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifie edical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) Muli 47683 MI 30. Nama and andress of person who completed causa of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) MAR 1 8 1999

Khymond Miller 25 Main Street 32. Registrer's Signature

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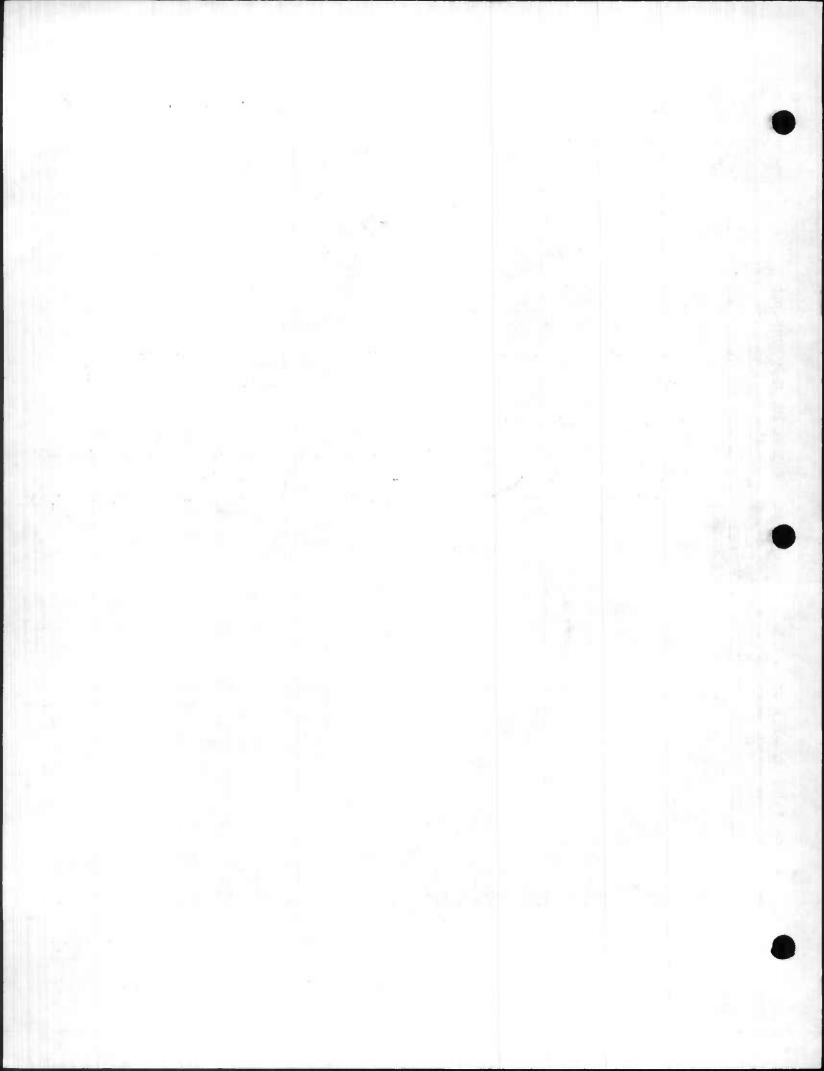
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State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Nama (First, Middle	Last)		00/1	ificate of	Dealli	2. Date of Dea	eg. No.	3	3. Time of Death		
Physician	JOHN F. SCHELLER 4s Facility Name (If not institution, give street and number)					Month MARC		Day Year		5:00 PM		
/Medical Examiner						4b. City, Town, or		10, 1,,,		J.00 III		
LABITITIES	1207 CIRCLE DR	IVE				BALTI	MORE	BAI	LTIMOR	E		
neral ector	215-07-5540	67	Age (In yrs. la 93	st birthday) Yrs.	If Under 1 Year Months Days					e (State or Foreign		
	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loca	ation				10d.	Inside City Limits		
ctor	MARYLAND BAL	TIMORE		BALTI	MORE					1 ☐ Yes 2 No		
Director	10e. Street and Number				10f. Zip Code		1	Og. Citizen of W	/hat Country	?		
	1207 CIRCLE DRI				2122			U.S.A.				
by Funeral	11. Maritel Status 1 Never Married 2 Marrie 3 X Widowed 4 Divorced	12. Was Deceder Armed Forces ad 1 Yes 2 Aff Yes, Give Year or Dates	5? No		as Decedent of Yes, specify Cut	Hispanic Origin? (S pan, Mexican, Puerl Specify:	pecify Yes or No- lo Rican, etc.)		- American k, White, etc. WHI			
Completed	(Specify only highes Elementary/Secondary (0-12)	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or				pation during most of wor ad)		16b. Kind of Bu				
	12TH GRADE 17. Father's Neme (First, Middle, L		2 YRS		MANAGER		ne (First, Middle,	FOOD DI:		IUK		
o Be	JOHN F. SCHELLER						MA FREID					
-	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailing	Address (Stree	t and Number or Au	ural Route Numbe	r, City or Town,	Stete, Zip Co	ode)		
	BERYL V. HOFFMA	N (DAUGHTE	R)	412 N	EEPIER 1	ROAD - BA	LTIMORE,	MARYLA	ND 212	28		
	20a. Method of Disposition 1 X Burial 2 ☐ Cremation		COI	metery, creme	tion (Name of story or other ple		Date	20c. Location -				
	4 Donation 5 Other (Sp		LUU.		RK CEME	1	3/20/99	BALTIM	URE, M	IARYLAND		
	21. Signature of Funeral Service L	SC		HU 41	07 WILK	UNERAL HO	JE-BALTIM	ORE, MA	RYLANI	21229		
	23a. Part1. Enter the disease, or o shock, or heart teilure. List of	complications thet caus only one cause on each	ed the death. line.	Do not enter	the mode of dy	ing, such as cardiad	or respiratory en	est,	Int	oproximate terval Between nset and Death		
n I r	Immediate Cause (Final disease or condition resulting in death) a. Cerebrarakular accident									,		
	resulting in death)			as a consequ					1	19 years		
Examiner		b	The same of the sa	ulnu	UM)				i	7 7 years		
Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.											
edical	Cause (Disease or injury that initiated events resulting in death) Last	C	Dua lo (or a	s a conseque	ence of):					8		
	Todaking in doubly Edis	d										
lan		0.							İ			
Physician/M	Part II. Other significant condition	s contributing to death	but not result	ting In the und	derlying cause g	iven in Part I.	The state of			e cause of death?		
by Ph							101	es 2 1 No	3 Probeb	oly 4□Unknown		
Completed b							24a. Wes e perfor	on eutopsy med?	availe	eutopsy tindings oble prior to eletion of cause ath?		
Con							1 🗆 Y	es 2 No	1□Y	'es 2□ No		
8	25. Wes case referred to medical examiner?	Hospital:			100		eth (Check only or	ne)				
. To	1 Yes 2 No 27. Manne of Death	1 ∐ Inpa		R/Outpatient	3LI DOA		lome 5 Resid		1-1-11			
Certification:	1 Naturel 5 Pending 2 Accident investig 3 Suicide 6 Could n	(Month, E	28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No.			Yes 2□No	28d. Describe how injury occurred			louis Atombas		
Certif	determined determined determined determined determined determined building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)				
edical		Physician: To the bes xaminer: On the basis and manner:	of axaminatio									
Σ	29b. Signature and title of certifier	× Q.	70	e no	29c. Licen	se number		9d. Date signed	ALC: UP TO			
A 1	1100.10	- 5 /SV	22/14 mar			ch/9/1229						
/	Namia	2 , 8 -			Ux			110000	4//	1 - 6 /		
Wedical Ce	30. Name and address of person w	ho completed cause of	death (Item 2	23a) (Type, P	rint)							

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day **Physician** Patricia Ann Simpson March 16, 1999 6:00 PM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Essex 40 Wagner Avenue 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral Months Days 1 M 20XF Hours 212-34-5150 Director 63 Dec. 14,1935 Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore Essex 1 Yes 2 No Maryland Director 28a-4 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 the Medical Examiner must be 21221 40 Wagner Avenue United States "natural", or flama 23a 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 11. Meritel Status 1 □ Never Merried 2 □ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 TNo Specify: Specify: White ğ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Hygiene. Florist 12 Years Floral Designer permit. Pages 1 and 2 should be the Department of Heath and Mental Hy important: if New 27 is marked other any injury or other the 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 86 Not Known Gordon Wareheime Virginia 19a. Informent's Neme/Reletionship (Type, Print) Daughter 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 40 Wagner Ave. Essex, Maryland 21221 Mrs. Valerie D. Schwab 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removal from State Hilltop Service Corp. 3/18/99 Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature of Panerel Service Licensee 22. Name and Address of Fecility
Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. BBSs. or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, in this only one cause on each line. Onsel and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Examiner physician and the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by 1 ☐ Yes 2 No 3 Probably 4 Unknown acture þ 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed been 1 Yes 2 No 1 ☐ Yes 2 No certificate Division of Vital 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death

1 Vietural

2 Accident Certification: 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending investigation 24 hours after death. 1 Yes 2 No 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as steted.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner steted. edical 29e. Certifier (Check only one) within 2 eg: 29b. Signeture end title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

7010

gistrar's Signature

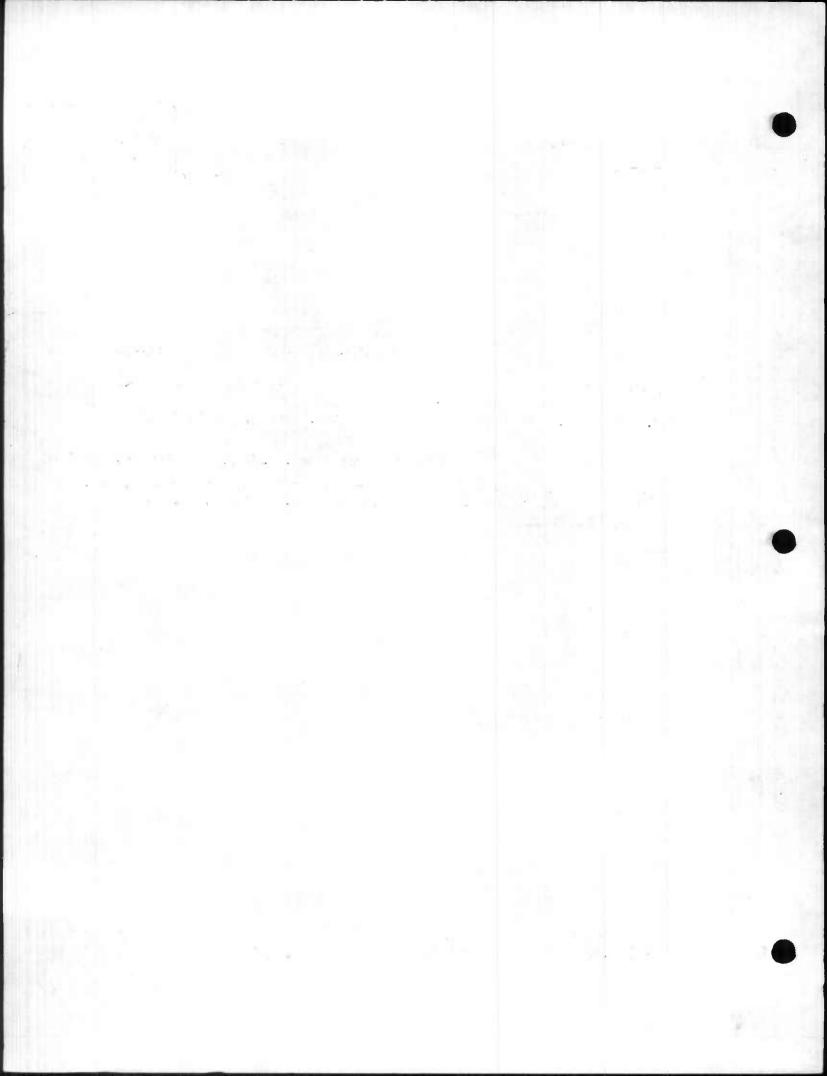
Ritchie

How Glan Burnie, MD 21061

30. Name end address of burson who completed cause of death (Item 23a) (Type, Print)

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Eichelberger



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth Dev Month Yeer **Physician** Katherine Marie Strobel March 18, 1999 12:10am /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 3603 Broadleaf Court Glenwood Howard 5. Social Security Number 7. Age (In vrs. last birthday) if Under 1 Year if Under 24 Hrs. Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** Deys Min 1□ M 2X F Months Hours 579-14-5405 76 Yrs. Director Nov. 11, 1922 Washington D.C. Usuel Residence of Decedent the Marylend 10e Stete 10c City Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, tra Madical Examinar must be notified at 1 ☐ Yes 2 No Director Prince George College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with 3505 Marlbough Way 20740 USA Funeral death Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, 11. Maritel Stetus Bleck White etc. filed within 72 hours efter 1 ☐ Yes 2 ☑ No If Yes. Give 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White à 3 ☑ Widowed 4 ☐ Divorced Yeer or Detes Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) . Pages 1 end 2 should be filed wirent of Health end Mental Hygien lant: If item 27 is marked other th jury or other traumatic event, Ins. Statistical Analyst F.B.I. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Roscoe McKnight Roach Pauline Moran 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Rosquist (Daughter) 3603 Broadleaf Court, Glenwood, Maryland 21738 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State Gate of Heaven 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 3/22/99 Silver Spring, MD permit. Page Department of Important: If eny injury or 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funerel Service Libera 5555 Twin Knolls Road, Columbia, MD 21045 0 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel Colos Crscer diseese or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner The law requires that the death certificate be executed pue buriel-tran Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): physician s the buriel Physician/Medical Due to (or es e consequence of) 50 USB 0 Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown g 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy Completed Deen page 2 s 1 Tyes 2 DANO 1 TYes 2 No certificate or Attending Physician: 25. Wes case referred to medical director. Be 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 8 NOther (Specify) The 4 has 2 1 Yes 20 No 2 ER/Outpetient 3 DOA this funeral 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Home After 5 Pending Investigation 1 Neturel efter deeth. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the ceuse(s) end menner as stated.

2 Madical Examinar: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end plece, and due to the ceuse(s) end menner stated. edicai 29a. Certifier To the I 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture and title of certifier

· Registra

State

30. Neme.

31. Dete filed (Month, Dey, Year)

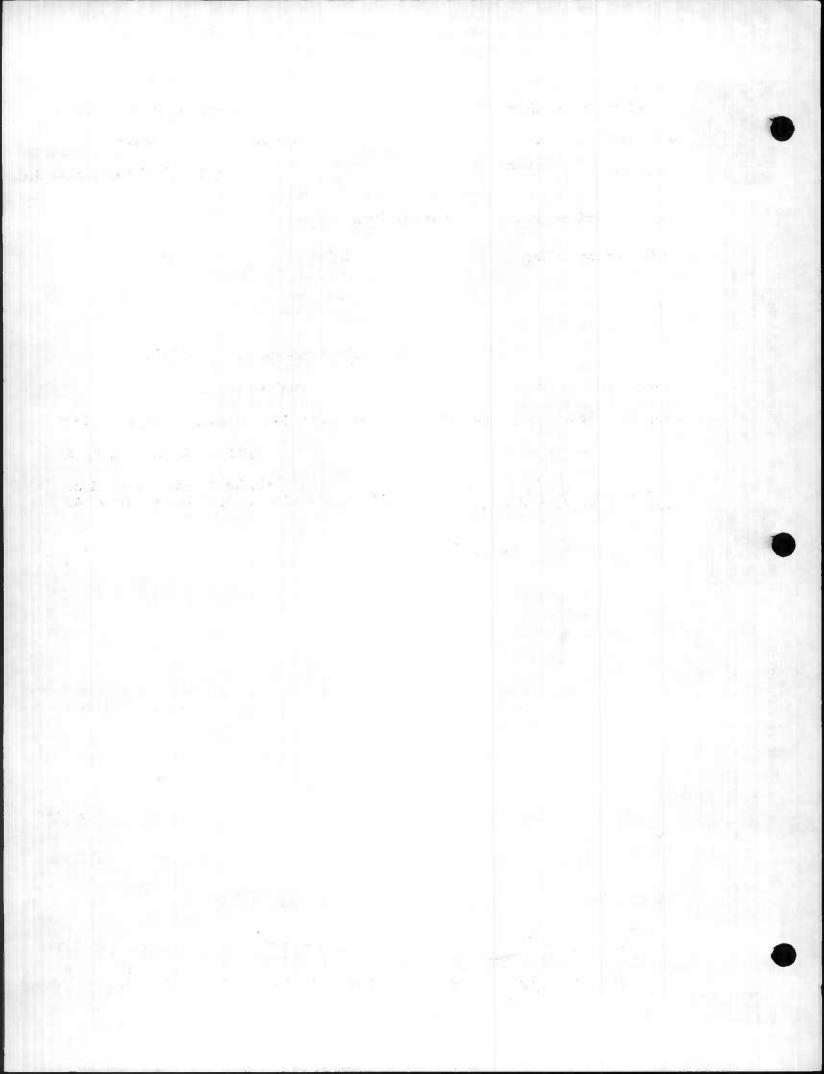
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raddress of person who completed cause of death (Item 23e) (Type, Print)

82. Registrer's Signeture

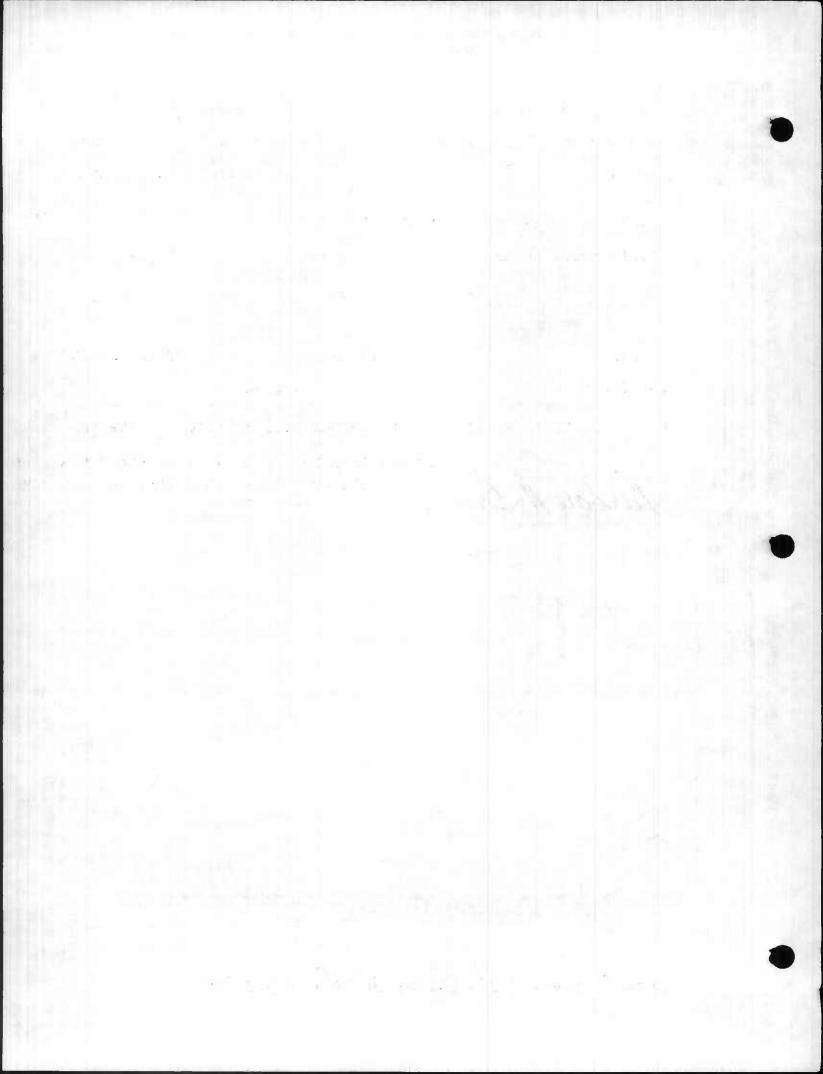
altimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



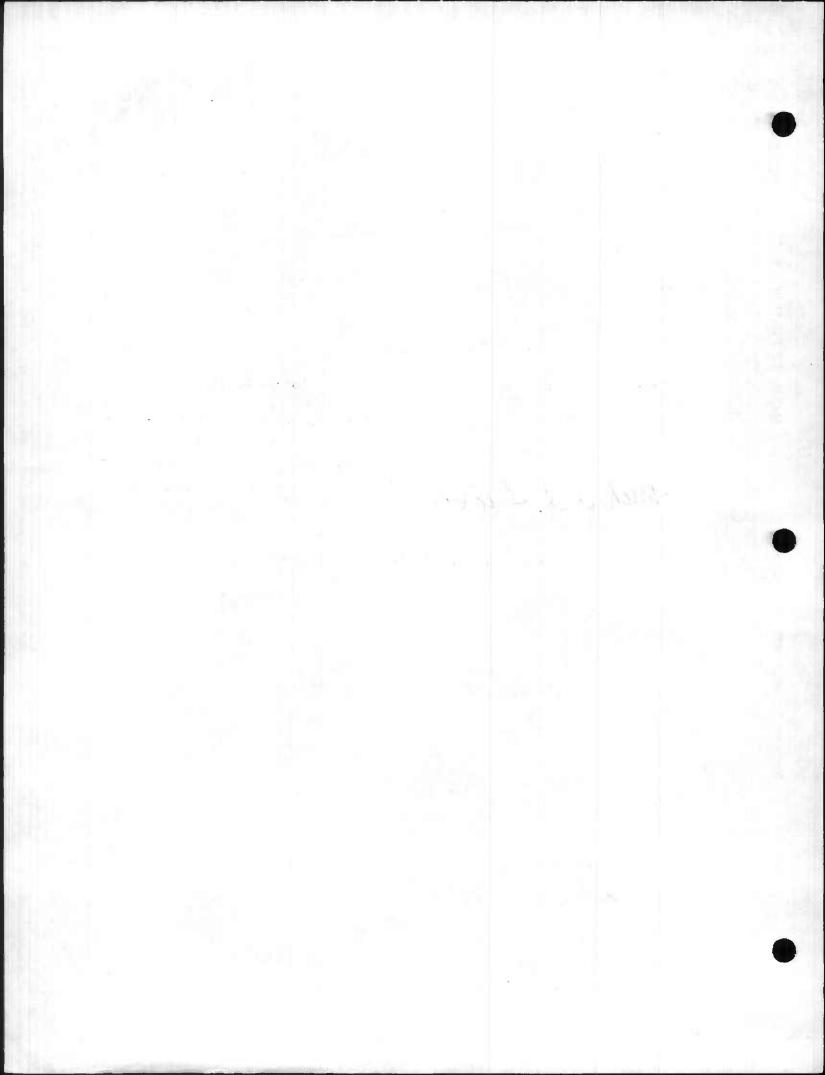
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Neme	(First, Middle, Las	st)		Cent	ificate of	Death	2. Dete of D	Reg. No.	3. Time of I	Deeth	
Physician		EY YS						Month MARCH	Day Y	ear		
/Medical	4a Fecility Name (If n						4b. City, Town, or					
Examiner			OF MARY	LAND			BALTIMOI			MORE		
Funeral	5. Social Security Num			e (In yrs. les	t birthday)	If Under 1 Year	If Under 24 Hrs	8. Dete of Bi		Birthplace (State or Country)	Foreign	
rector	214-18-72 Usuel Residence of D	271	□M 2IXF	83	Yrs.	Months Days	Hours Min	AUG 1		MARYLAND		
ad at	10a. State	10b. County		10c. City, 7	Town or Loca	tion				10d. Inside City	Limits	
other traumatic event, the Medical Examiner must be notified at	MARYLAND	BALTIM	IORE	В	ALTIM	ORE CO	UNTY		1 ☐ Yes			
be notified Director	10e. Street end Numb	per				10f. Zip Code			10g. Citizen of Whet Country			
al D	1901	TALBOT	STREET			212	207		U.S.A			
Funeral	11. Marital Status		12. Was Decedent 6 Armed Forces?	Ever in U,S.	13. Wa	as Decedent of	Hispanic Origin? (S	Specify Yes or N	0- 14. Race -	American tridian, White, etc.		
þ	1 N Never Merried 3 □ Widowed 4		1 Yes 2XXX If Yes, Give Yeer or Dates:	jo		Yes M No				BLACK		
Completed	(Specify	5. Decedent's Ed	lucation	1	16a. Deceder	nt's Usuel Occu	pation	orkina	16b. Kind of Bush	ness/Industry		
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2	JAMES N	10NROE					unkno					
	19a. Informent's Nam	e/Relationship (7	Type, Print)		19b. Mailing	Address (Stree	et end Number or F	lure! Route Numi	ber, City or Town, St	ete, Zip Code) 212	0.7	
			tt/Frien	d	1901	Talbo	t St.,		ore, Mai	cyland		
	20e. Method of Dispos		Removel from State	20b. Pled	a of Dispositi etery, creme	ion (Neme of tory or other ple	ece)	Dete	20c. Location - Cl	ty or Town, State		
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3	Wirbara H Trous 1206 W NORTH										PA	
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Physician/M	L MURY									1		
sic	Part II. Other significa	Part II. Other significant conditions contributing to death but not re-					ot resulting in the underlying cause given in Pert I.			bute to the cause o	death?	
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Completed										of deeth?		
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To Be	Yes 2 No 27. Manner of Deeth	0	1 ☐ Inpatie	- /	VOutpatient 3b. Time of	3 DON	4 Nuising	1	how injury occurred			
0	1 Natural	5 Pending	(Month, De)	Yeer)	Injury	M 1E	ork? Yes 2 No	200. Describe	now injury occurred			
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edical	29a. Certifier (Check only 2)	□ Certifying Phy □ Medical Exam	ysician: To the best of	examinetion	age, death on end/or inve	scurred at the t stigation, in my	ime, date end plac opinion, death occ	a, end due to the curred at the time	cause(s) and menr , date end pleca, en	er es steted. d due to the ceuse(s)		
Med	29b. Signeture end tit	le of certifier	and manner sta	1.80.		29c, Licen	nse number		29d. Date signed (Month, Dev. Yeer)		
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	30 Name and addres	s of person who	completed cause of de	eeth (Item 23	3a) (Type, Pr	D. C	IM	71701				
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State of Maryland / Department of Health and Mental Hygiene

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4	/Medical	Mark J.		atmat and a conh	and a			4b. City, Town, or				10:30 F.M.
d	Examiner	12803 Holi			ier)		100	Bowie	Location of Death	4c. County		orge's
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	h with the Me 13a or 28a-f s at be nouried	10e. Street and Number 12803 Holi	day La	ne			10f. Zip Code	20716		Og. Citizen of V United		
020	within 72 hours effer deeth with the Meryland ane. then "natural", or flams 23a or 28a-f show for Medical Exercise must be notified at some and the Funeral Director	3 ☐ Widowed 4 ☐ I		12. Wes Decede Armed Force 1 ☐ Yes X If Yes, Give Year or Dete	es? IXI No		les Decedent of h Yes, specify Cub ☐ Yes ※ No	pecify Yes or No- to Rican, etc.)		k, White,	ean Indien, etc. nite	
Baltimore, Maryland 21215-0020	yglene. The than "neturity, the than "neturity, the Males. Completed	15. [(Specify on Elementary/Secondery	Decedent's Ed by highest grad (0-12)	de completed)	ation completed) College (1-4or 5+)		O NOT use retire	lone during most of working		16b. Kind of Bu		
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and	d be filed and other c event, n	17. Father's Neme (First,						18. Mother's Name (First, Middle, Maiden Sumeme) Lucile Donahue				
ary.	2 should be send Mental Is marked or reumatic eve					19b. Meiling	Address (Street	and Number or Ri	ural Route Numbe	r, City or Town.	Stete, Zip	(Code)
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Balti	permit. Pe Departmen Important: any injury		1. Signeture of Funeral Service Licensus Waldorf Maryland 22. Name and Address of Fecility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715									
		23a. Pert1. Enter the dis shock, or heart faile	eese, or comp	lications that bau	ed the deeth.						nd_20	Approximete Intervel Between
	Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in deeth)		. Me		es a consequ		creat	ica	inder		Onset and Deeth
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of Vital Records,	been s should								24a. Wes a		ev	ere autopsy findings aliable prior to impletion of cause death?
Ä	yelclen: The lew is certificate hes director, page 2								1 U Y	es 20 No	10	Yes 2□ No
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Div	al Direction by	4 Homicide	determined	28e. Place of building,	Injury - At hon , etc. <i>(Specify)</i>	ne, lerm, stre	et, lactory, office		281. Location (S City or Tow		er or Hura	al Route Number,
	n 24 hound no Funer pletely fill	29a. Certifier (Check only 2 1	Certifying Phy Medical Exam	sician: To the be iner: On the basi and menner	s of examination	ledge, death on and/or inve	occurred et the ti estigation, in my o	me, date and place opinion, deeth occu	e, and due to the d arred et the time, d	ause(s) end ma late end place,	nner es si and due to	lated. the cause(s)
	Within To the Common Co	29b. Signeture end title o	f certifier				29c. Licens	se number	- 4	29d. Date signer	d (Month,	Day, Year)
	,04	(la	us	2		1	9500		3 /	15	-194.
	US	30. Name and address of	person who c	ompleted cause of	Shine/	23a) (Type, P	int)	lestern	aved h)ison	curl	reston D.C.
	State Registrar	31. Date liled (Month, Da	y, Year) 9 1999	32. Regi	istrar's Signatu	9. de	254621		1-4			



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 112000 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 L. Stanley 5:55 A.H. Jacquelin 4a Facility Nama (If not institution, giva street and number) 1999 4b. City, Town, or Location of Death 4c. County of Death Gilchrist If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Baltimore Center If Undar 1 Yaar Months Days 5. Social Security Number Birthplaca (Stata or Foraign Country) A / T 6 Sax 7. Age (In yrs. lest birthday) 1□M 2 F Days N.J. 158-38-8849 Usual Rasidance of Decedent Yrs. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore NA Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4019 U. S.A Avenue 2/2/6 10 12. Was Decedant Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Giva Year or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Naver Marriad 2 Married 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Allegheny East e of 7th Day Elementary/Secondary (0-12) College (1-4or 5+) evene 12th grade years Adventist 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Massenburg I homas Lank ford Flizabeth 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Shelton Balto, Md Carlisle Avenue Stanley-Husband 4019 21216 20b. Placa of Disposition (Neme of cametery, cremetory or other pleca) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Ramoval from State 3-18-99 0 Wings 4 ☐ Donation 5 ☐ Other (Specify) narrison torest Vet 22. Name and Address of Facility 21. Signature of Funaral Service Licenses Jarch F. H. West Balto, 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tellure. List only one cause on each line. wabash 21215 Approximate Intervel Between Onset and Death Immediate Ceuse (Final CANCER 6 months disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as a consequenca of) 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2200 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 280 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of

Physician /Medical Examiner

Examine

Physician/Medical

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Completed

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1 Metural

2 Accident

3 Suicida

29a, Certifier

4 | Homicide

(Check only one)

5 Pending

investigation

6 Could not be determined

Important: If its any injury or o page.

Physician

/Medical

Examiner

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Funeral

Director

7 is marked other than "natural", or items 23s or traumstic event, the Medical Examines must be a

pernit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s

altimore.

of Vital Records. Division

Certification: 24 hours Funeral edical To the F

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at tha time, data and place, and due to the cause(s) and manner as steted. 2 Medical Examiner: On the besis of exam and menner stated. ninetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) 29b. Signature and title of contino

29c. License number 1 MD

29d. Date signed (Month, Dey, Year) MArch 13,1999

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

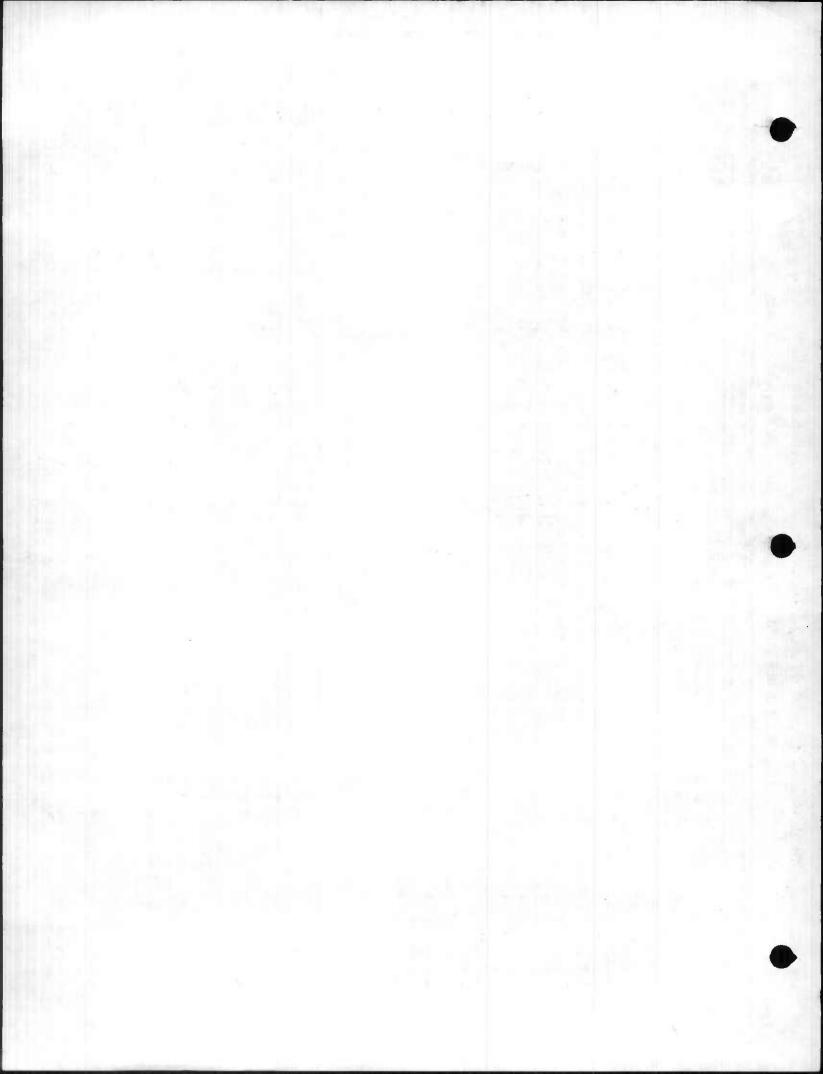
30. Neme and eddress of person who completed cause of eth (Item 23a) (Type, Print)

W. A. Riley N. Churles St. Balto. and Zizox 6Bmc 6701

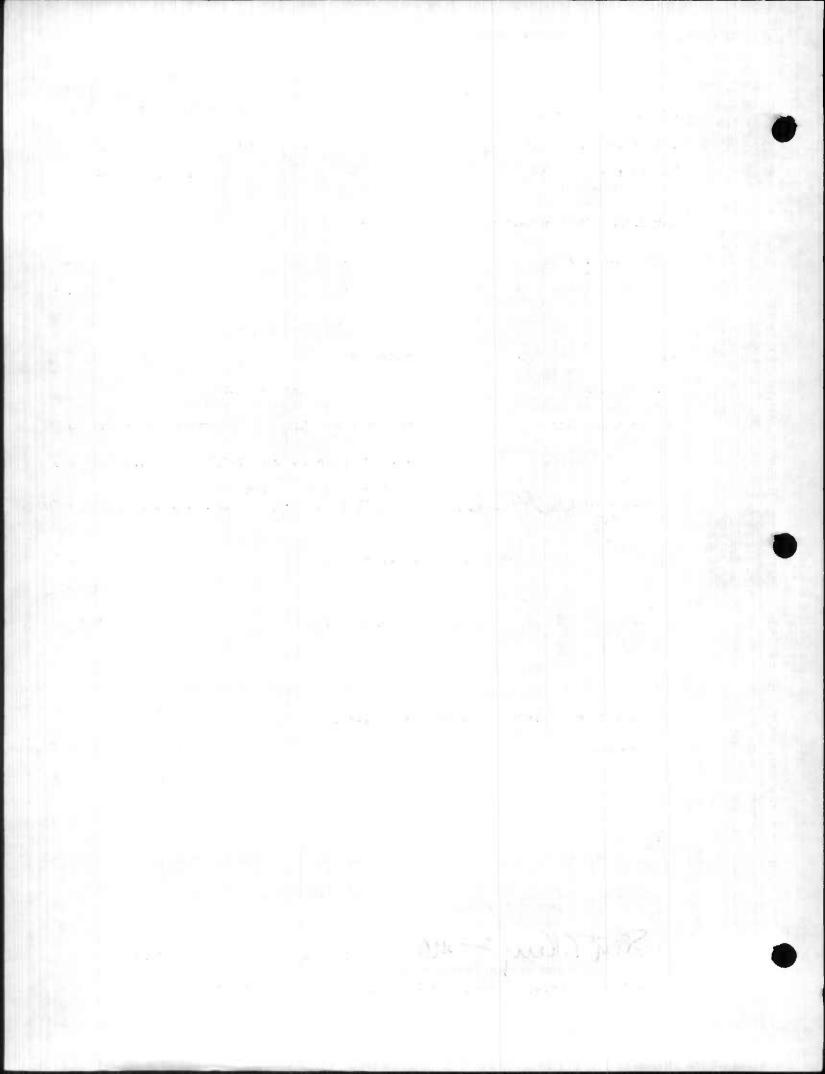
1 Yes 2 No

31. Date tiled (Month, Day, Year) MAR 19 1999 32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

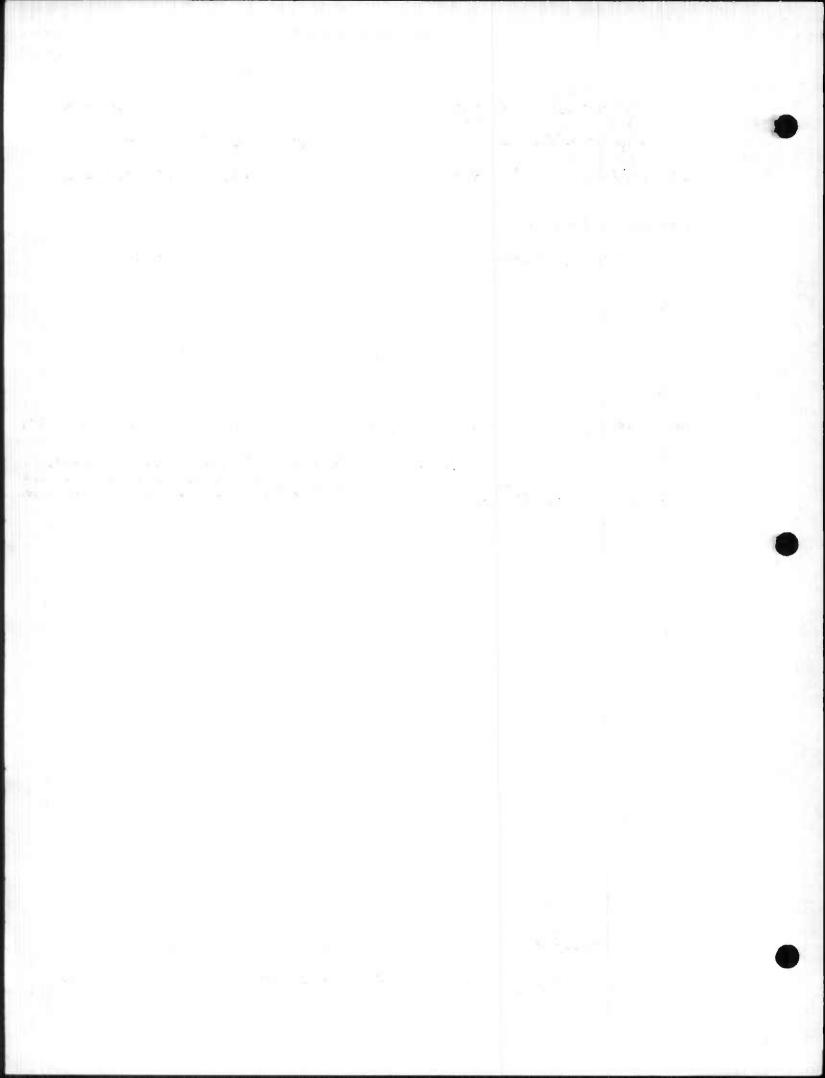


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		I Security Number	6. Sex		7. Age (In yrs	ge (In yrs. lest birthday)		Year If	ilver Under 24 Hr	s. 8. C	ate of Birth Month, Day,	Year)	ntgomery 9. Birthplace (State or Foreit Country)		te or Foreign	
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	Usual F	Residence of Decedent	nhe		100 0	ity, Town or Lo	cation						10	d Ineid	e City Limits	_
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					10f. Zip Code								WHAT COUNT	ıy:		
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g		15. Deced	ient's Educ	ation		16a. Deced	lent's Usual C	Occupatio	n			16b. Kind of Bu	usiness/Ind	ustry		
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any injury or other traumetic bace.		formant's Name/Relatio		pe, Print)								, City or Town,				
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			1. Decedent's Neme (First, Middle, Last)					2. Dete of De	eath		3. Time of Death
	Physici		Edna	Spriggs				Month 3	B Dey /6	Yeer QQ	8 am
5	/Medi		4e. Facility Neme (If not Institution, give	Spriggs			4b. City, Town, or	r Location of Dear		of Death	
2	Examir	ner	College View C					ERICU, M	,	eder	1-6
Į.			5. Sociel Security Number 6. Sen		last hirthday	/) If Under 1 Yee					
	Funeral Director			M 201 86	Yrs.	Months Deys		12/2	rth ay, Year) 3/19/2	MAR	lace (Stete or Foreign try)
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	the Mary 28a-f sh	Director	MARY AND FRECIER	CICK		10f, Zip Code			10g. Citizen of V	After Cours	1 □ Yes 2 No
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ŏ	2 hou		15. Decedent's Edu	cation	16e. Dece	edent's Usuel Occi	upetion		16b. Kind of Bu	usiness/Ind	lustry
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é	- 2 5 5		20e. Method of Disposition	20b. 1	Pieca of Disp	position (Name of ematory or other pi	ise Ave.	Dete	20c. Location -	City of To	4nd 021701 wn, Stete
altimore			1 Burial 2 □ Cremetion 3 □ R 4 □ Donetion 5 □ Other (Specify)								
Ball	permit. Page Depertment of Important: If any injury or otice.		21. Signeture of Funerel Service Licanse	90	Ĵ	22. Neme and Add tome, 4	coll PAR	THE DEI	erick a	- Jon	MARY/And UES FUNERA BALTIMORE
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Œ	0 4 8	Eo						10	Yes 20 No	1 🗆	Yes 2□ No
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of	r this	T:C	27. Manner of Deeth	28a. Dete of Injury	28b. Time	of 28c. Ini	iury et		how injury occur		/
o	ding F th. After diner	tion	1 Neturei 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		ork? □ Yes 2 □ No				
Division	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury - At h building, etc. (Specif	ome, farm, s fy)	treet, fectory, office	0		(Street end Numb wn, State)	er or Rura	Route Number,
	Hospital 24 hours Funeral stely filled	edical C	29e. Certifier (Check only one) 1 Certifying Phys	sician: To the best of my knoner: On the besis of examine end menner steted.	owledge, dee otion end/or in	th occurred et the nvestigetion, in my	time, dete and pled opinion, deeth occ	ca, and due to the curred et the time	cause(s) and ma , date end plece,	inner as st and due to	ated. the cause(s)
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	po p		30. Neme end eddress of person who co	mpleted cause of death (item	n 23e) (Type	80/	D43091 TOLL &	touse A	VE, I	CREI,	Erick
	Sta	ite	31. Dete filed (Manth Day, Year)	32. Registrer's Signe	eture	/		Α			



State of Maryland / Department of Health and Mental Hygiene 0

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 1430 March Alvin Wayne Shorter 1999 16 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Baltimore 1325 Maple Ave. Arbutus If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) 10/10/1946 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** 12 M 2□ F Months Deys Hours Min. 216-44-5353 Director Tennessee Usual Residence of Decedent the Maryland d 2 should be filed within 72 hours after death with the Marylan had Mental Hyglene.
7 is marked other than "naturel", or ferma 23a or 28a-f show treumstic event, 12 Medical Engineer must be notified as 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Arbutus 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1325 Maple Ave. 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 0 2 / 0 8 / 6 8 If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

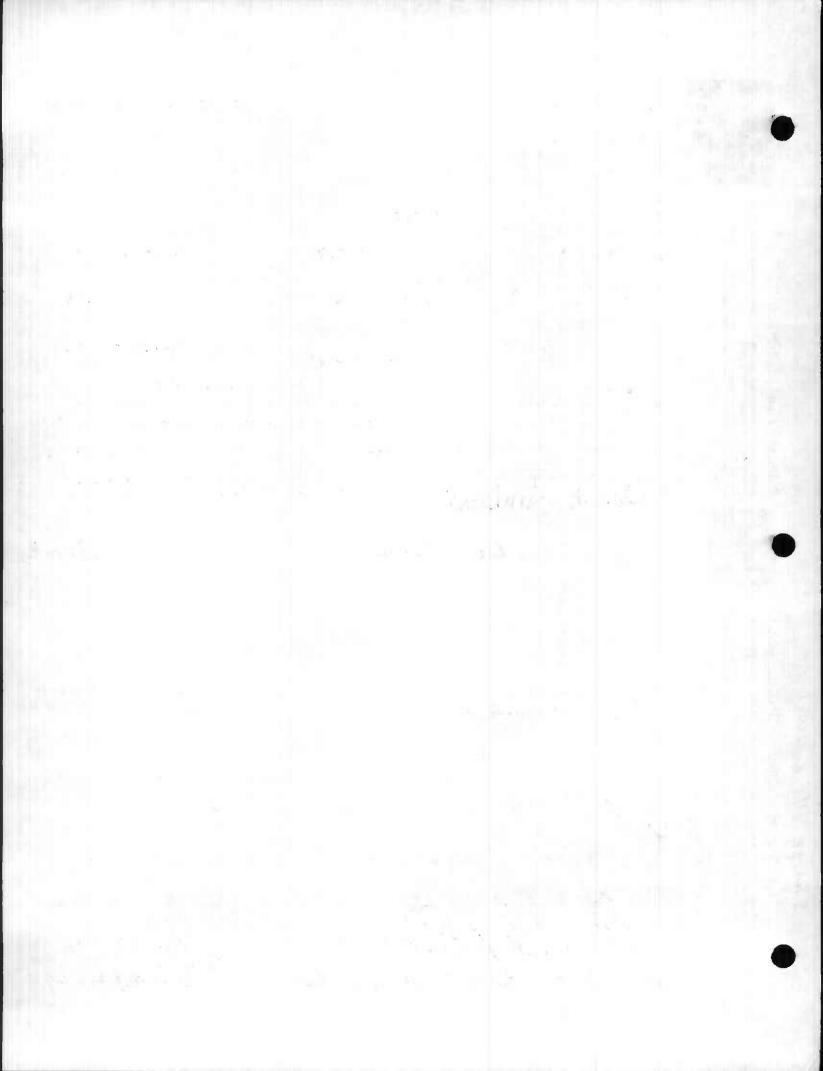
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 2 / 1 4 / 7 2 14. Raca - American Indian. Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decadent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Environmental Groundskeeper 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be unknown Della Mae Shorter 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m eny injury or other treum Betty Smith/sister 1325 Maple Ave. Arbutus Maryland, 21227 20b. Placa of Disposition (Name of cametery, cremetory or other pleca)
Loudon Park 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 3/22 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Funeral Service Licanse 22. Name and Address of Facility Mbrose Funeral Home, Inc. Spring Rd. Arbutus, MD21227 1328 Sulphur 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es a consequence of): of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): usa as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown signed by Metastases þ 8 24a. Was an autopsy performed? 24b. Were eutopsy findings available prior to Completed completion of cause of death? 1 Yes 2 NO 1 Yes 2 No certificata funeral director, 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending deeth. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) or A 4 | Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and placa, end due to the cause(s) end manner as steted.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier edical (Check only one) 29b. Signature and tiple of certifier 29d. Date signed (Month, Day, Year) 30. Negre and address of 31. Date filed (Month, Dey, Year) 32. Registrer's Signature 9 Registrar

DHMH 16 Rev 6/95

WAYNG

SHORTOR



State of Maryland / Department of Health and Mental Hygiene Item 17, 18 Per FH FilmG769 3-31-99 rja Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Year Susanna Sturnberg February 1999 1:12 AM /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner 5809 Edson Lane Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funerai** Days Months 10 M 20 F Vrs Director 578-60-7922 Feb. 27 1921 Hungary Usuel Residence of Decadent 10b. County 10e. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral', or items 23a or 28a-f el Examiner must be notified Director XX Yes 2 □ No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5809 Edson Lane 20851 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ∑ No It Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Rece - American Indien, Bleck, White, etc. 11. Marital Status filed within 72 hours efter 1 Never Merried 20 X Married 21215-0020 "natural", or 1 ☐ Yes XX No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed th end Mental Hygiene.
7 is marked other than "natur traumatic event, the Medical 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) Housewife Her Home Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumame) . Peges 1 end 2 should be fii ment of Health end Mental H lant: if item 27 is marked oth Jury or other traumatic even Zoltan Nusbaum Bartos Elizabeth Bartos Nussbaum 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 10502 Redosier Ct., Bethesda, MD Peter Schissler/Son-in-law 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete ▼ Buriel 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) permit. Pege Department of Important: If any injury or 2/9/99 Lebanon Cemetery 22. Name end Address of Fecility
Takoma Funeral Home 21. Signeture of Funerel Service Licensee 254 Carroll Street Washington, DC 20012 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tellure. List only one ceuse on each line. Approximete Interval Between Onset end Deeth Physician CANCER OVARIAN /Medical Immediete Ceuse (Finel diseese or condition resulting in deeth) Examiner Due to (or es e consequenca ot): Examiner The law requires that the death certificete be executed buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last pue Due to (or es e consequence of): P.O. Box 68760, Physician/Medical the Due to (or es e consequence ot): 9 esn Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t d be detach 1 Yes Z No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings evellable prior to completion of ceuse of deeth? page 2 should Completed 24a. Wes en eutopsy performed? 1 Yes 2 No this certificete 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: director, 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home Sparesidence 6 Other (Specify) Medical Certification: To 1□ Yes 2□No 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Neturet 2 Accident 5 Pending efter death. Investigation 1 TYes 2 TNo 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, term, street, tactory, office building, etc. (Specify) filled In by 4 Homicide 24 hours e Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

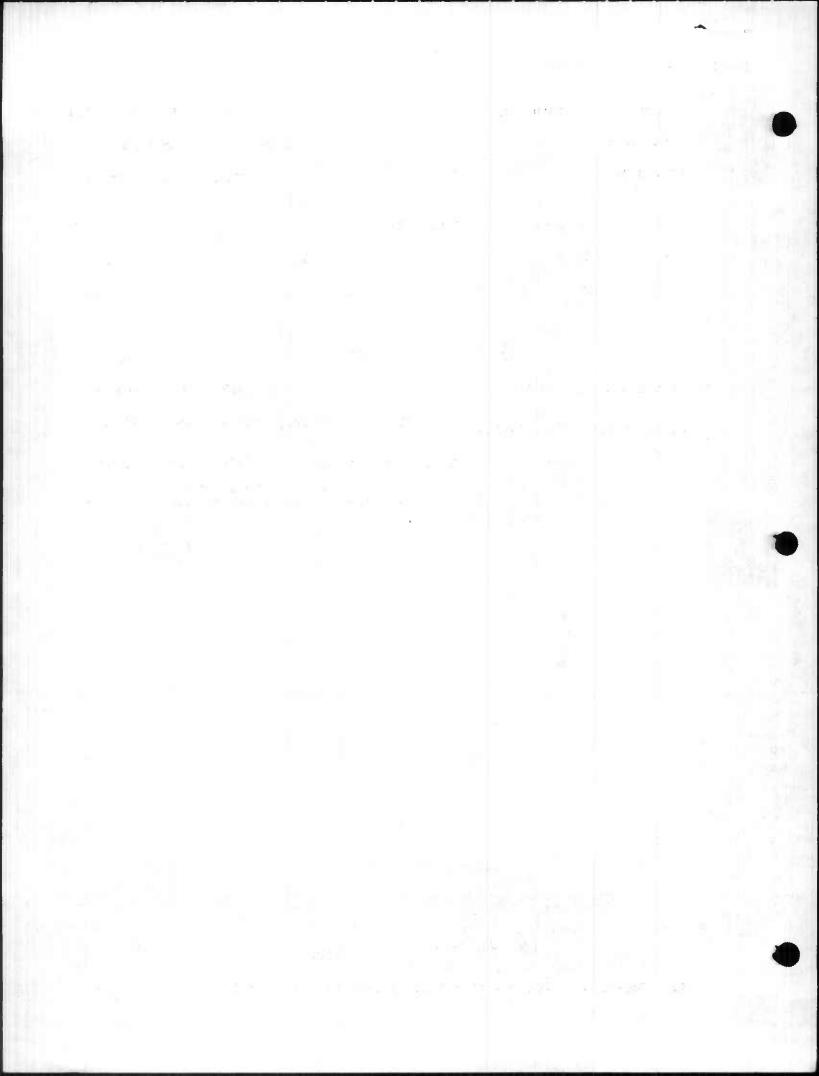
2 Medical Example: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner/stated.

1 title of certification.

29c. License number.

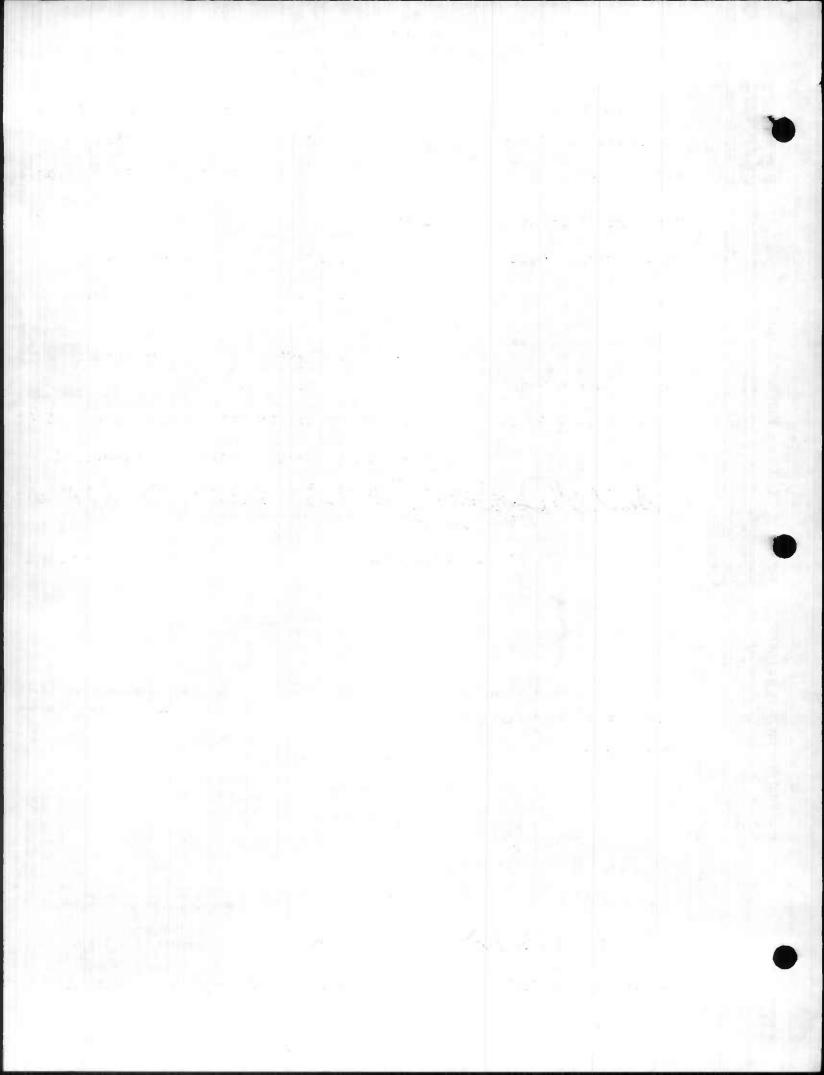
29d. Date signed (Month, Dev. Year) 29a. Certifier To the within 2 29b. Signeture end title of certilia 29c. License number 29d. Date signed (Month, Day, Year) D 16495 30. Name and address of person who completed dayse ot death (Item 23e) (Type, Print) Joel Goozh, MD 4 31. Date filed (Month, Dev. Year) 4701 Randolph Road, Rockville, MD 20852 22. Registrer's Signeture State

Registrar



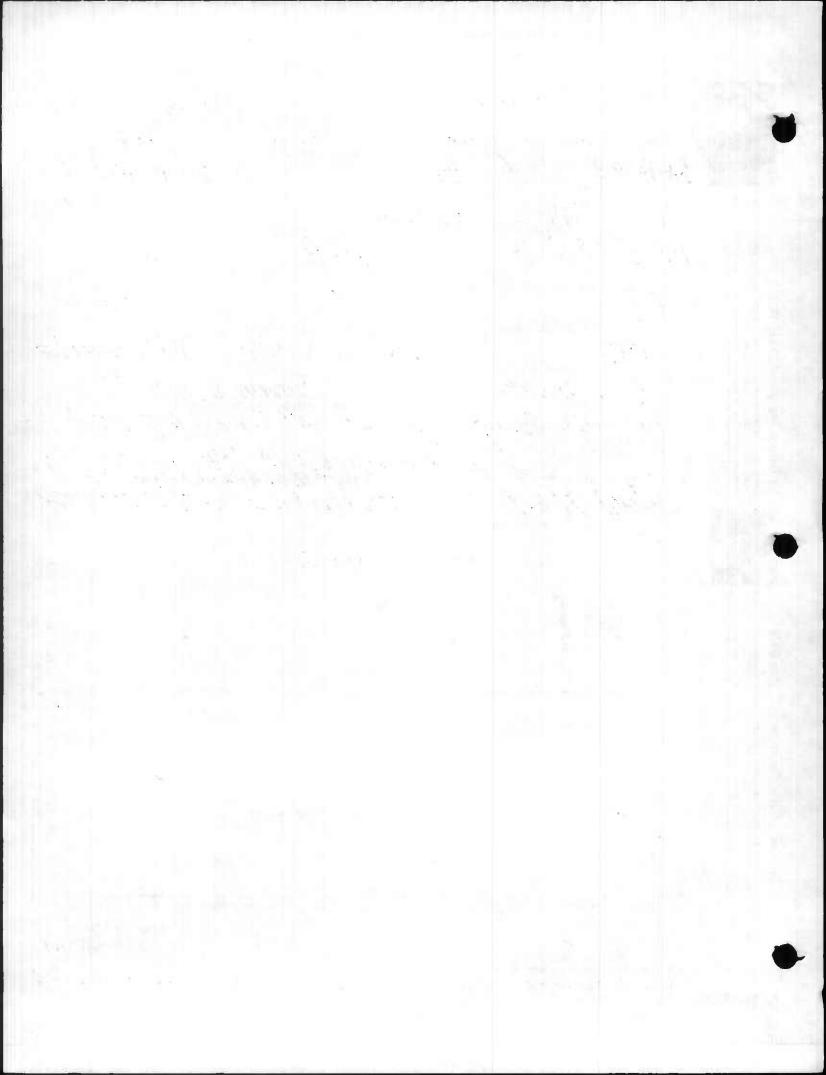
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Dete of Death 3. Time of Death Day **Physician** 1999. Dale. SHUCK March 16, $2.30 \, \text{pm}$. /Medical 4a Feclity Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Catonsville Baltimore Catonsville Commons If Under 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months 87 Yrs. 214-07-1858 July23,1911 Pennsylvania Director Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 1110 21207 United States 1 2 should be filed within 72 hours efter death in and Mental Hyglene. Is marked other than "natural", or itema 234 Mirga Circle Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dales; Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: White by 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Press Operator Garment 10 other traumatic svant, 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Eva Pearl Sherman John Luman Lehman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) permit. Peges 1 end 2:
Department of Health et
important: if item 27 is
eny injury or other trau 1110 Mirga Circle Baltimore, Maryland 21207 Wayne Ronald Shuck Baltimore, 20b. Placa of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 X Buriai 2 ☐ Cremation 3 ☐ Removel from Slate Loudon Park Cemetery 3/19/99 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility 21. Signature of Funeral Service Ligensia Ambrose Funeral 1328 Sulphur Spr ose Funeral Home, Inc. Arbutus Sulphur Spring Rd. Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not dister the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in dealh) /Medical Broncho-Pneumonia. Three Days. Examiner Due to (or as a consequence of): Examiner certificate be executed ician end burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medicai Due to (or as e consequence of): 80 980 death for ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Degenerative Joint Disease signed Division of Vital Records, à 2 should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed peen Hypertension completion of cause of death? 705 page 2 The 1 Yes 2 No 1 ☐ Yes 2 ☒ No certificete or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) To 1 Tyes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. injury et Work? Certification: 5 Pending 1 ⊠Neturai 1 ☐ Yes 2 ☐ No 24 hours efter death. investigation 2 Accident 6 Could not be determined Localion (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29a. Certifier 1X Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end menner steted. (Check only one) within 2 the 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number March 16, 1999. D30469. 1el 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) 9055, Chevrolet Drive, #Suite 100, Ellicott City, MD 21042. N B Vellanki, MD: 31. Date filed Month, Day, Year) 32. Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygieneo 0 000 5

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Funeral Director	220-18-9819 Usual Residence of Decedent	10 M 200F 80	Yrs. Months	Days Hours Min.	8. Data of Birth (Month, Day,	1918 M	ARGIAND
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inter deeth with the Mar r items 23s or 28s-f si niner must be notified Funeral Director	218 E. 23ra	1. St.	10f. Zip (218		g. Citizen of What C	
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yojene. Ter then "netural; It, the Wederal Ex. Completed by	15. Decedent's 8 (Specify only highest ga	ducation ade completed)	16e. Decedent's Usuel (Give kind of work	Occupation done during most of work	king	6b. Kind of Business	s/Industry
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and Menta and Menta is marked sumatic ex	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Address	(Street and Number or Ru	ral Route Number,	City or Town, State,	Zip Code)
and 2 aaith ar n 27 is wer treu	Watakis 1	TERRY	2165.	23VAGT.	BALT	m9, 2	1211
parmir. rages I and Department of Health Important: If Item 27 I any Injury or other tr. 000.0	20a. Method of Disposition	/ Ao	metery, cremetory or of	e of	Date / 2	Oc. Location - City o	Town, Stete
rages nent of l int or o	1 ☑ Burial 2 ☐ Gremation 3 4 ☐ Donation 5 ☐ Other (Spec	Hamovai from State	M2121CAL LTV	205671/A.	3/10/00/	Junes M	16 110
parmit. Pa Departmer Important: any Injury once.	21. Signature of Funeral Service Lice		22. Narrie and	Notifies of Paches	Hinasa	Churs	DA
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Physician	shoek, or heart failure. List only	one cause on each line.					Onset end Deet
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intrate be assorted g physicien end as the burial-transit edical Examiner	Sequentially list conditions.	b. Due to (or	es a consequence of):				
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The law require cate hes been significant page 2 should Completed					24a. Wes en		. Were eutopsy finding available prior to
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ding P. Aftar t funara	27. Menne of Death 1 DNeturel 5 Pending	(Month, Day Year)		Bc. Injury et Work?	28d. Describe hor	w Injury occurred	
daeth daeth tor: A / tha f	2 Accident investigation 3 Suicide 6 Could not	he	М	1 Yes 2 No	006 1		2. m. / Day to Alimbar
or Attendent dest Director:	4 Homicide determine	28e. Plece of Injury - At hor building, etc. (Specify,	me, farm, street, fectory,	offica	City or Town,	eer and Number or i Stete)	Rural Route Number,
he Hospital or Attending Pi 24 hours after daeth: he Funeral Director: After the plataly filled in by the funeral edical Certification:							
Fune faly fi	29a. Certifier Certifying P	hysician: To the best of my know miner: On the besis of examineti					
To the Hospital or At within 24 hours effer of To the Funeral Direct complately filled in by Medical Certifi		end menner steted.	200	Licansa number	20	d. Data signed (Mo	oth Day Year)
0 ₹ 0 0 ~	29b. Signatura and titla of certifier		290.				
	The Cle	venga ms		P11144		March	13,1999 ogylano
	30. Neme and eddress of person who			1 (2 11	vs /	00116
	Ann Clevene	101-		1 Center	Balti	more IV	ogey land
State Registrar	31. Date filed (Month, Day, Year)	32, Registrer's Signet	ure /				
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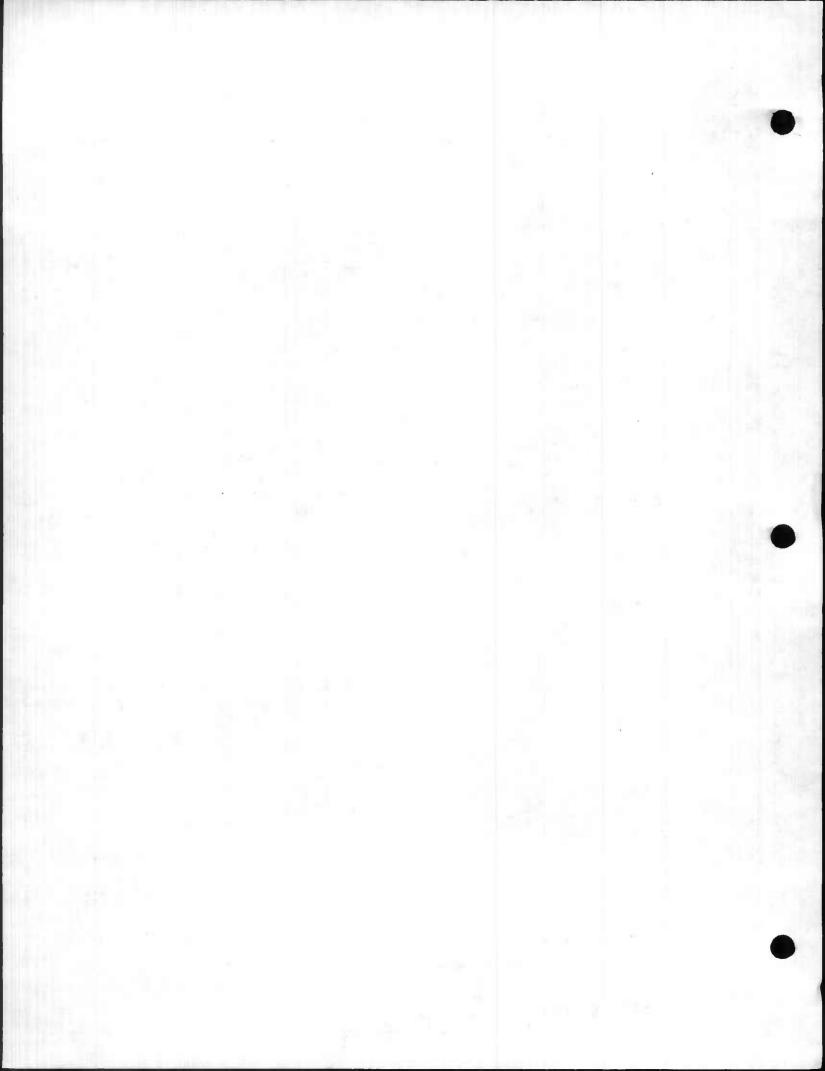
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** March 18, N. Helen 1999 Tucker 8:15 AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health of North Arundel Glen Burnie Anne Arundel 7. Age (In yrs. last birthday) 81 Yrs. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 10 M 2 DF Days Director 218-03-7542 December 30,1917 Virginia Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or leams 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director Maryland N/A Baltimore 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 Funeral 1010 Druidon Court USA death 12. Wes Decedent Ever in U,S.
Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Meritel Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examinations. Bleck, White, etc. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: White Specify. p 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8 Homemaker Household 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Anthony Guzick Helena Babyak 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 1508 Rochester St., Crofton, Thomas Tucker - Son MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Metro Crematory, Inc. 4 ☐ Donetion 5 ☐ Other (Specify) March 20 Baltimore, MD 22. Name and Address of Facility Stallings Funeral Home, P.A. 21. Signeture of Funerel Service Licensee 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause by each line. 3111 Mountain Road, Pasadena, MD 21122 Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel Myscerdid disease or condition resulting in deeth) ours Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Hypertennion PV 24b. Were autopsy tindings sveilable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case reterred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 量 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending Investigation Attending 1 Neturel 1 Yes 2 No To the Hospital or Attend within 24 boars after death Je (15s Furlish all Director A Completely Illied in by the 1 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steted. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier NO D-40521 March 19, 1999 30 Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 3350 Wilkens Arenuc OCHANES Battimore, MD 21229 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State MAR 1 9 1999

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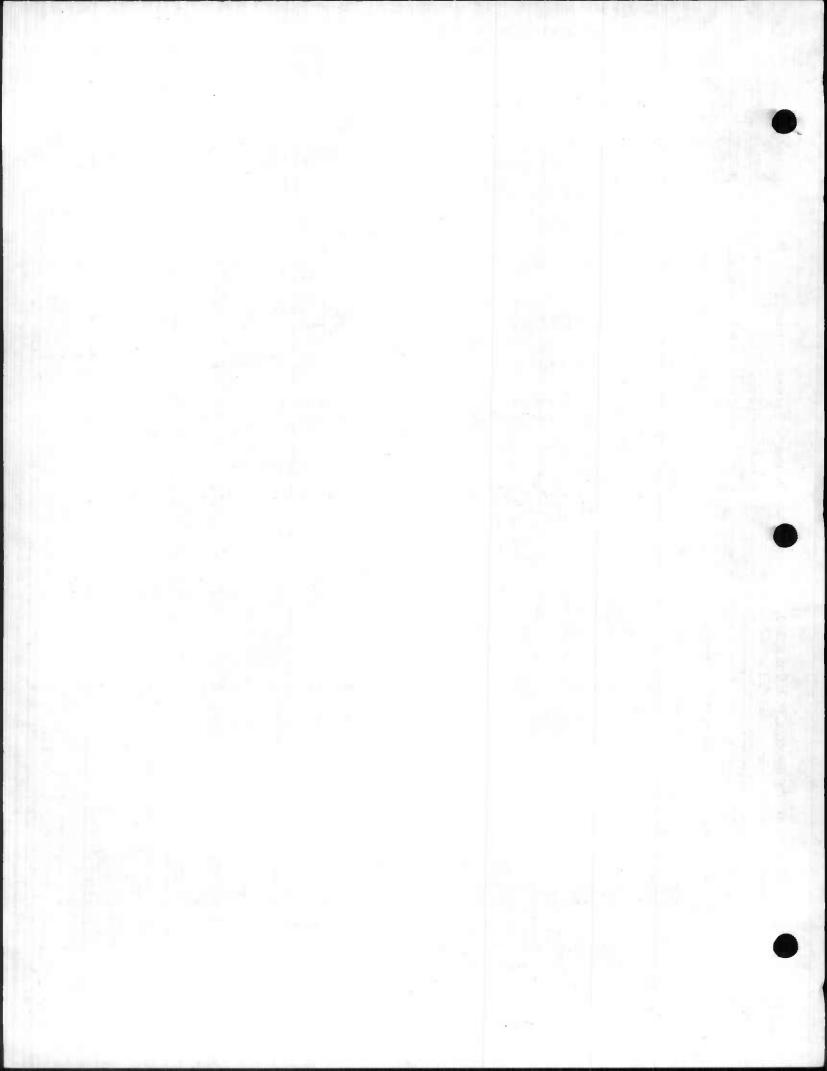
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ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

_	Decedent's Name (First, Middle, Last)		Cer	tificate of	Death	2. Dete of Det	Reg. No.		3. Time of Death	
Physician	Dorothy P. VanKer	khove				Month March	Dey	Year 1999	4:05 pm	
/Medical Examiner	4a Facility Name (If not institution, give s	treet and number)			4b. City, Town, or L				4:03 bill	
Examine	Mariner Health of	North Ar	undel		Glen Bur	nie	Anne	e Aru	inde1	
ineral rector	000 10 1000	7. Age (h	n yrs. last birthday) Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birt (Month, De) April 1	0,1912	9. Birthp Coun New	lece (Stete or Foreign try) York	
	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation				1	0d. Inside City Limits	
rector	MD Anne Arur		Severn			1 ☐ Yes				
Director	10e. Street and Number			10f. Zip Code			try?			
0	1213 Somerset Roa	ad		211	10g. Citizen of What Country? USA					
by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Wes Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of I Yes, specify Cub	dispanic Origin? (Span, Mexican, Puerto Specity:	pecify Yes or No- b Rican, etc.)	Blec	- Americ k, White, Whi	etc.	
Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	ent's Usuel Occup	pation during most of work	kina	16b. Kind of Bu	siness/Inc	dustry	
ompi	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	O NOT use retire	d)				TIN	
ន	17. Father's Name (First, Middle, Last)		Inspe	ctor	18. Mother's Nen	a /First Middle	Genera:		amics	
ToBeC	Adelbert Baker				Leah La		Maidell Sullielli	9)		
J.	19a. Informent's Neme/Relationship (Typ	a. Print)	19b Mailin	a Address /Street	and Number or Ru		er City or Town	State 7in	Code)	
	Sally C. Lynch (I			The state of the s	set Road,				0000)	
	20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)		20b. Plece of Dispos	sition (Neme of netory or other ple	ce)	Dete	20c. Location -	City or To		
any injury	21. Signature of Funeral Service License	Hull	22		y Funeral ely Avenu			4D 21	401	
	23a. Part1. Enter the disease, or complice shock, or heart feilure. List only one	ations that coused the	death. Do not ente						Approximete Intervel Between	
cian ical iner	Immediate Cause (Finel disease or condition resulting in death) a.	. /	statie	Cyner	to the	Liver		1	Onset and Deeth	
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ician/	Part II Other plantificant conditions and	Shution to double but a	nt negation in the co	dad dan as as as	una in David	20h Didd	-h	delburg de	the source of death?	
by Physician/M	Part II. Other significant conditions cont	nouting to death but n	ot resulting in the ur	idenying cause gr	ven in Part I.	23b. Did tobacco use contribute to the cause 1 Pres 2 No 3 Probably 4			bably 4 Unknown	
page 2 should be detached Completed by Physic						24a. Wes	en eutopsy med?	eva	ere eutopsy findings aileble prior to mpletion of cause death?	
director, page To Be Com						101	es 20 No	10	Yes 2 No	
8	25. Was case referred to medical examiner?				26. Plece of Dee	ith (Check only o	ne)			
10	1 Yes 2 Ne	ospital:	2 ER/Outpatien	3LI DOA		ome 5 Resid	dence 6 Oth	er (Specif	y)	
Certification:	27. Manner of Death 1	28a. Date of Injury (Month, Day Ye			ry at rk? Yes 2 □ No		now injury occurr			
Certif	4 Homicide determined	28e. Place of Injury building, etc. (S	Specify)			City or Tow	vn, Stete)		il Route Number,	
pletaly filled in by the funaral edical Certification:	29a. Certifier (Check only one) 1 Oertifying Physical Examine	cian: To the best of m or: On the basis of exa and menner stript	y knowledge, death aminetion and/or inv	occurred at the ti estigation, in my	me, date and place opinion, deeth occu	, end due to the or rred et the time,	ceuse(s) end ma date end place, a	nner as si and due to	tated. o the cause(s)	
8 2	29b. Signature and title of pertilisis	- 14		29c. Licens	se number		29d. Date signed	(Month,	Dey, Year)	
1	· Ellay	8 PK	2	12	0094		03/1+	144		
Y	Ellioff Gos	pleted cause of death	7845	Oakur	od Rd.	6-kg	Burnie	, 140	1,21061	
State Registrar	31. Date filed (Month, Day, Year)	37. Registrar's	Signature	10000	/			(1	



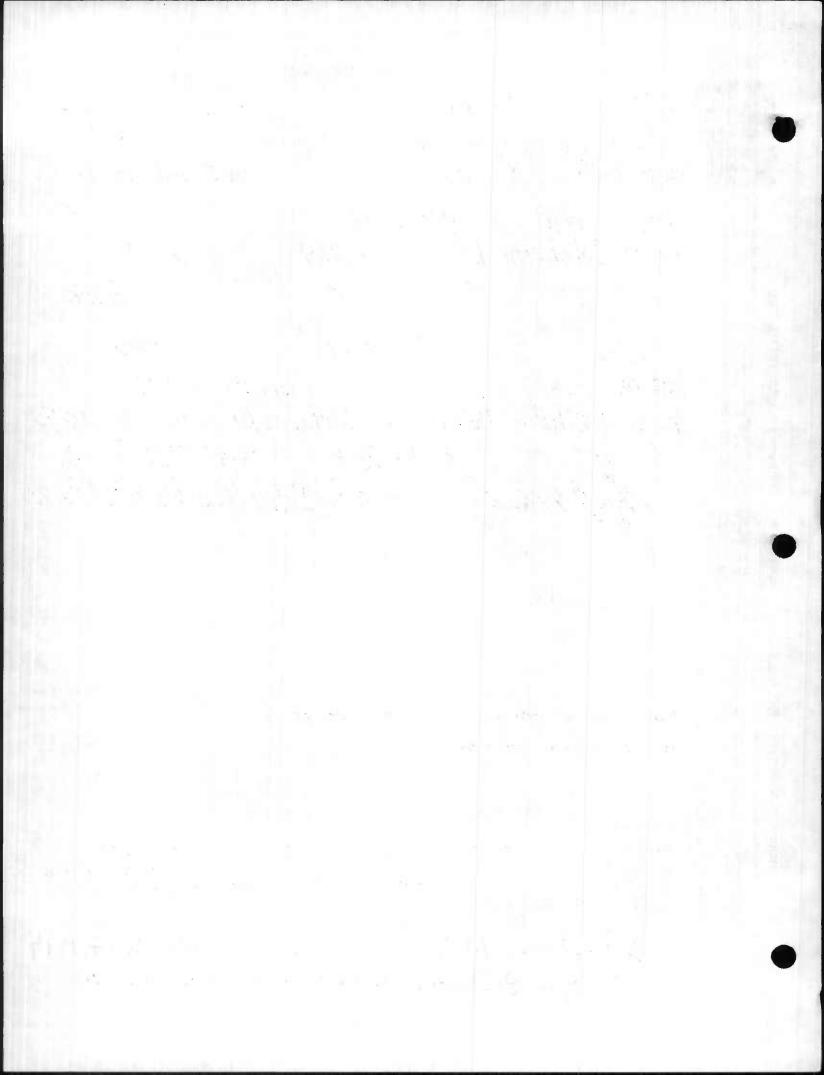
99-1491-510 crn Ethel Walker

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene o

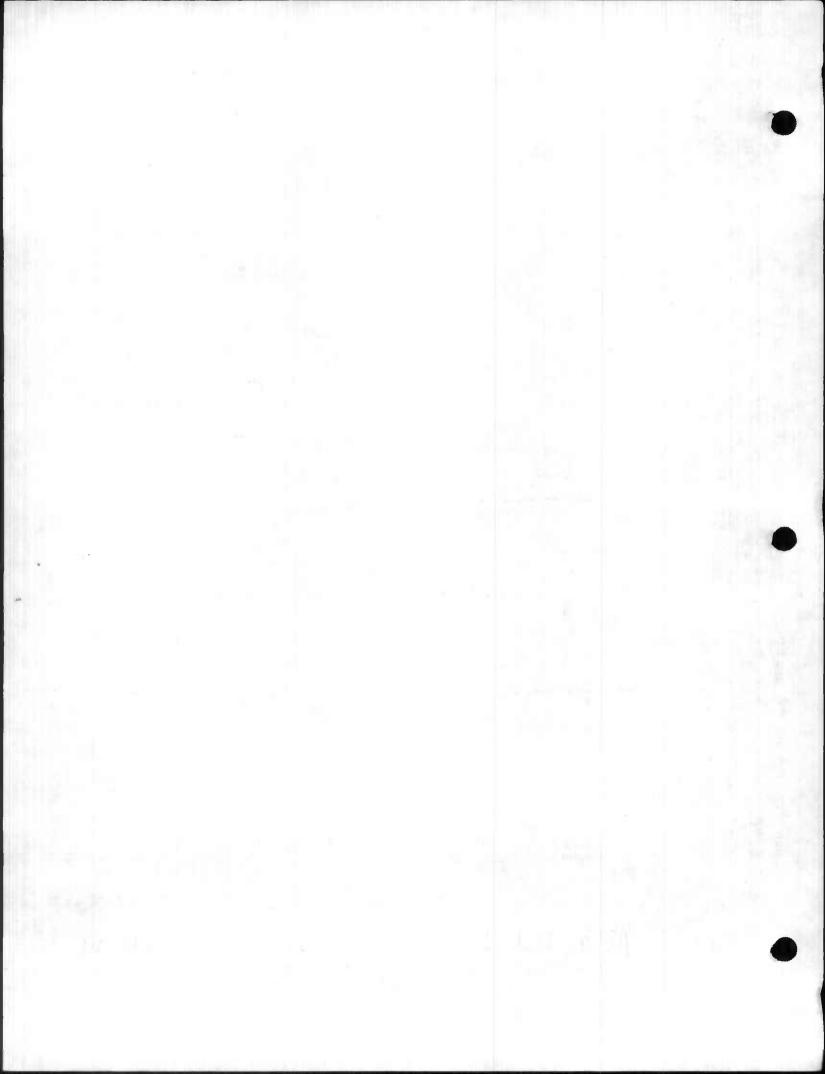
			Sertificate of Death	Reg. No.	00000
	1. Decedent's Name (First, Middle, L.	ast) 11/4 11/0		2. Date of Death	3. Time of Dea
Physician	EthellE	. Walker		Month Day	1999 2:29 P.
· /Medical	4a Facility Name (If not institution, gir	ve street and number)	4b. City, Town,		County of Death
Examiner					
		ryland, Shock Trau Sex 7. Age (In yrs. last birth	The state of the s		N/A
neral		ADM OFF OF		Hrs. 8. Date of Birth Min. (Month Pay, Year)	9. Birthplace (State or Fo
tor	Usual Residence of Decedent	0.1		VEC. 00, 191	I HAIZIATION
4	10a State 10b. County	10c. City, Town	or Location		10d. inside City Li
rector	MD M	A PAIH	imore		1 Yes 2
90	10e. Street and Number	[M]	101. Zip Code	10g Citiz	zen of Whet Country?
Funeral Director	4015 10101	DACAD DA	21200	//	CA.
era	1010 00101	12. Was Decedent Ever in U.S.	12 Was Decedes of Hispania Origin	7 (Specify Venerale 1	14. Race - American Indien,
Š	11. Meritel Status	Armed Forces?	 Was Decedent of Hispanic Origin it Yes, specify Cuban, Mexican, P 	uerto Rican, etc.)	Black, White, etc.
by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 1 No if Yes, Give	1 Yes 2 No Specify:		Specify: BIMK
		Year or Dates:		405 60	0/40/
Completed	15. Decedent's E (Specify only highest gr	ade completed)	Decedent's Usual Occupation (Give kind of work done during most of file. DO NOT use retired)	working 160. Kir	nd of Business/Industry
E C	Elementary/Secondary (0-12)	College (1-4or 5+)	0115011160	1	10ME
ပိ	10\TM	1//	UI U CUI I E	Name (First, Middle, Maiden	Su-see)
To Be C	17. Father's Name (First, Middle, Las	0.1	18. Mother's	CON CO CALLE	1//
2	MIMICON LUIS	+4	17/01	tille rowt	100
	19a. Informant's Name/Relationship	(Type, Print) 19b.	Mailing Address Street and Number of	r Rural Boute Number, City of	Town, State, Zip Code)
	Drielly HUNTI	UTTIE VIKUSITA	1015 COLETIENTIE	KO. DE110.	,1110. 010a-
	20a. Method of Disposition	- cemeters	Disposition (Name of r, crematory or other place)	Date 20c. Lo	cation - City or Town, State
	1 Burial 2 Comation 3 C		4 HORK	0120149 (00)	SVIIIE, IVID.
	21. Signature of Pundral Secrice Lice	nsee /	22. Name and Address of Facility	di Cinana	11hma 00
8	19.71	W//	Gary E man	GO TESTET WIT	14/119/1/2/10/10
	23a. Part Enter the comana, or och	positions that caused the death. Do no	of arrive the mode of divino such as on	reliac or respiratory errest	Approximate
,	shock, or figure failure. List only	npictrions that caused the death. Do no one cause on each line.			interval Between Onset and Deat
an cal	Immediate cause (Final	1133 0	Trade and a se		
ner	diseas of condition resulting in death)	Head and Chest	injuries		
a	CATURED IN	Due to (or as a co	onsequence of):		
Examiner		b			
Xar	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury	Due to (or as a co	onsequenca of):		
	ceuse. Enter Underlying Cause (Disease or Injury	C			
C	that initiated events resulting in deeth) Lest	Due to (or as a co	onsequence ot):		
/Medical		d			
		0.			i
Completed by Physician	Part il. Other significant conditions	contributing to death but not resulting in	the underlying ceuse given in Part i.	23b. Did tobacco	use contribute to the cause of de
hy	Umortonaire	arteriosclerotic	cardiovacoular	1 🗆 Yas 2)	No 3 Probably 4 □ Unik
by	nyper tensive and	arterioscierotic	Carutovascular		
8	disease; Pulmona	ry emphycema		24a. Wes an autop	available prior to
z should	discuse, idiliona	ry anpriysana.			completion of caus of death?
Com				1 🕱 Yes 2 🛭	□ No 1 1 X Yes 2 □ No
O	25. Was cese reterred to medical		Of Plans of		100
o Be	axaminer? XXYes 2□ No	Hospital: 1 ☑ inpatient 2 ☐ ER/Out	Othor	Death (Check only one)	T00
.7	27. Manner ot Death		patient 3L DOA 4L Nursi	ng Home 5 ☐ Residence 8	
o	1 Natural 5 Pending	(Month, Day Year) In	jury Work?	200. Dosonos non injur	, 00001100
cat	Accident investigation	03-11-99 /:3	80 P	Fell down s	
Certification:	4 ☐ Homicide determined	28e. Place of injury - At home, fan building, etc. (Specify)	m, street, tactory, oπice	City or Town, State	d Number or Rural Route Number, 4305 Liberty Ht
ပိ		Ho	me	Ave., Baltir	nore, MD
edical		hysician: To the best of my knowledge, miner: On the basis of examination and			
8	one)	and manner stated.	To an obligation, army opinion, double	obstitute at the time, date and	place, and due to the eader(e)
Medical Certif	29b. Signature and title of certifier	7.4.	29c. License number	29d. Dat	e signed (Month, Day, Year)
	1 1 Pit	aner M.D.	O.C.M.E	. May	rch 17.199
	30. Name and address of person who	completed cause of death (Item 23a) (T	Type, Print)	Ţ,	1,1,1
	()Taceal	1 POSTAMPE	111 Penn Street,	Baltimore, Ma	aryland 21201
State	31. Date filed (Month, Day, Year)	32. Registrer's Signature			-
	and the state of t	OLI FIGURE OF OUR WORLD			

Registrar



State of Maryland / Dep	partment of Health	and Mental	Hygiene
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		State of Maryla		artment of I		d Mental Hy	rgiene	0.8	999	
	1. Decedent's Neme (First, Middle, Last,)				2. Date of Do				
Physician /Medical	MILDRED M. WHA	LEN					16, 1999		9:03 A.M.	
Examiner	4a Facility Name (If not institution, give		, or Location of Deat	Death 4c. County of Dea						
	GREATER BALTIMORE 5. Social Security Number 6. Sec) If Under 1 Year	TOWS			LTIMO		
Funeral Director		OM 21X F 85	rs. last birthday Yrs.	Months Days		Min. 8. Date of Bi	0, 1913	9. Birthple Counti MARY	ace (State or Foreign ry) I AND	
Director	Usual Residence of Decedent					1.0 11	0, 1,10	TIART	LAND	
srylan show dat	10a. State 10b. County	10c.	City, Town or L	ocation				10	d. Inside City Limits	
or 28a-f s be notified	MARYLAND N/A		BA	ALTIMORE					1X Yes 2 No	
Me or	10e. Street and Number 4322 BREHMS LANE			10f. Zip Code 21206			U. S		ry?	
her death or thems 23 sheer must have must Funeral	11. Merital Status	12. Was Decedent Ever in	2. Wes Decedent Ever in U,S. 13. Was			? (Specify Yes or No		e - America	n Indian,	
72 hours after death with the Maryla natural, or livens 23e or 28e-f show side Examiner must be notified at steed by Funeral Director		Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		 13. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify: 			Specify Specify	ck, White, etc. 'y: WHITE		
Matural Scaling	15. Decedent's Edu (Specify only highest grade	cation	16a. Dece	dent's Usual Occu	ccupation 16b			usiness/Indu	ıstry	
ad within 72 hours at ygjene. we than 'natural', or it the Medical Exam Completed by F	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retire		WOTKING				
	10TH GRADE 17. Father's Name (First, Middle, Last)			HOMEMAK	IAKER OWN HOME 18. Mother's Name (First, Middle, Meiden Sumame)					
d 2 should be file th and Mental Hy 7 is marked other traumatic event To Be C						MAY SCHOL		10)		
should marks marks To	19a. Informant's Neme/Relationship (Ty		or Rural Route Numb		State, Zio (Code)				
	THOMAS BRIAN WHALE								7.	
of Heart Them	20a. Method of Disposition	20a. Method of Disposition 20b. Place of Disposition (Name of competent comp								
nit. Pages artment of i ortant: If he injury or o	1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donetion 5 ☐ Other (Specify)		ARKWOOD			3/19/99	BALTIMO	RE, M	ARYLAND	
pamit. Pages 1 at Department of Hos Important: if them any injury or other once.	21. Signature of Funerel Service Licensee Bucin & Willem 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME INC. 3331 BREHMS LANE, BALTIMORE, MARYLAN								21212	
Physician /Medical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Acute Myo	ocardia.	1 Infarct				2	Interval Between Onset and Death Hours	
The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Lischemic Heart Disease Due to (or as a consequence of): Due to (or as a consequence of):								/26/89	
Seath certing attending of for use a lclan/M	dd									
es that the death certification by the attending by the detached for use as the by Physician/Mec		imbuting to death but not t	ath but not resulting in the underlying cause given in Part I.				Yes 2X No		ably 4 Unknow	
The law requires the state has been signed, page 2 should be d			- 1	259 V		24a. Was	an autopsy ormed?	con	re eutopsy findings lable prior to pletion of cause eath?	
Con Con						10	Yes 2 No	10	Yes 2□ No	
Physician: this certific ral director,	25. Was case referred to medical examiner?	lospital:		Or	hor	Deeth (Check only				
or Attending Physician: The law requires that death. Director: After this certificate has been signe in by the funeral director, page 2 should be certification: To Be Completed by	27. Menner of Death 1 Natural 5 Pending	1 ☐ Inpatient 2 28a. Date of Injury (Month, Dey Year)	X ER/Outpatie	of 28c. Inju	ry at ork?		idence 6 Oth how injury occur)	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	2 Accident investigation 3 Suicide 6 Could not be determined	treet, factory, office	1 ☐ Yes 2 ☐ No ry, office 281. Location (Street and Number or Run City or Town, Stefe)			per or Rural	Route Number,			
To the Hospital of within 24 hours at To the Funeral D completely filled it.	29a. Certifier 1 Certifying Phya (Check only one)	alcian: To the best of my k nar: On the basis of exami and manner stated.	nowledge, deal netion and/or in	th occurred at the ti nvestigation, in my	ime, date and popinion, death	place, and due to the occurred at the time,	cause(s) and m date and place,	enner as ste and due to	eted. the ceuse(s)	
To the Complex of the	29b. Signeture and title of certifier	- 11 1		29c. Licen	se number		29d. Date signe	d (Month, D	Pay, Year)	
	1 m/m. F	approlper		028673 3 1199			19			
	30. Name and address of person who co	mpleted cause of death (II	tem 23a) (Type	Print) NEAL	W. TO	CHAZ OBL	ER, m.) 1		
	G B M C , 6701 N.	Charles Str	eet, Ba				,			
State	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	1 .						
Registrar	MIND I Y 1999	A STATE OF THE PARTY OF THE PAR	6.1	200, 11 1						



State of Maryland / Department of Health and Mental Hygiene

RIA V. WII	LSON Certificate of Death	h	Reg. No.	03000		
Discreteles	1. Decedent's Name (First, Middle, Last)	2. Date Mon	of Death oth Day	Year 3. Time of Death		
Physician /Medical	Gloria Virginia Wilson		,	1313 PM		
Examiner	4a Facility Nama (If not institution, give street and number) 4b. City, 7	Town, or Location of		ty of Death		
	ST. AGNES HOSPITAL BALT	TIMORE		N/A		
Funeral	o. ood firm you and british the part of the second of the	lar 24 Hrs. 8. Date	of Birth	9. Birthplace (Stata or Forai Country)		
Director	217-32-8022 1 M 2 F 72 Yrs. Months Days Hours		5. 1926	Maryland		
within 72 hours after death with the Maryland ene. then "naturel", or items 23s or 28s-f show for Madical Evaritiest fruit be notified a	Usual Residence of Decedent	1010	2, 1/20	Train y Lama		
Mow	10a. State 10b. County 10c. City, Town or Location			10d. Insida City Limi		
r 28a-f show incritied at frector	Maryland Baltimore Baltimore	2		1 ☐ Yes 2 ☒ N		
or 28	10e. Street and Number 10f. Zip Code		10g. Citizen o	f Whet Country?		
23a o	349 Bigley Avenue 21227			USA		
r items 23s or 28s-fs from must be northed Funeral Director	11. Marital Status 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic	Origin? (Specify Yes	or No- 14. R	ace - American Indian,		
F. F.	1 □ Nevar Married 2 □ Married 1 □ Yas 2 ☑ Nó			lack, White, atc.		
þ	3 Na Widowed 4 □ Divorced Yaar or Datas:	ify:	Spec	White		
	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of	Business/Industry		
r, the Medical Ex.	(Specify only highast grada complated) (Giva kind of work dona during median (Secondary (0.12)) College (1.4ov 5.)	lost of working	1000			
E	Elementary/Secondary (0-12) College (1-4or 5+) Sales Associat	te	Reta	il		
O	17. Father's Nama (First, Middla, Last) 18. Mot		Middla, Maidan Sumi	ama)		
o Be	Ferdinand Harrison Reuwer	Ida Flor	ence UN	IK		
70	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Melling Address (<i>Street and Num</i>					
traumetic event, To Be C	Charles D. Wilson/Son 349 Bigley Aven					
ther		Date Dall		1D ZIZZ/ n - City or Town, State		
or othe	1 Burlal 2 Cremation 3 Removal from State cematary, cramatory or other place)			1 - 1 - 1		
Jury	4 □ Donation 5 □ Othar (Specify) Metro Crematory, I		3/17/99 Baltimore, MD			
Important: If any Injury or once.	21. Signature of Funeral Segree Donnes Cremation So	ociety o	f MD. In	IC.		
E = 0	Edward A. Gregorchik 299 Frederic	Baltimo	re, MD 21228			
	23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such a shock, or heert failure. List only one cause on each line.			Approximate Interval Between		
ysician	A 1 1- ()		A-	Onset and Death		
Medical	Immediate Cause (Final disease or condition ATTERIOS CONTROL ON SUCCESSION OF CONTROL OF	· or under	Vicena	0		
aminer	rasulting in death) Due to (or as a consequence of):	3000	2000			
ē l	Dua to (or as a consequence or).					
the buriei-trensit	b. Due to far as a consequence of:					
EXE	Sequentially list conditions, if any, leading to immediate					
	Sequentially list conditions, if any, leading to immediate ceusa. Enter Underlying Cause (Disease or injury that initilited events Due to (or es a consequence of): c					
edical	resulting in death) Last Due to (or as a consequence of):					
0 =	d					
detached for use						
ysic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Per	ert I. 23		contribute to the cause of deat		
Phy	Waketer Hellitus		1 ☐ Yes 2 ☐ No	3 Probably Unkno		
b be				T		
page 2 should		248	a. Was an autopsy performed?	24b. Were autopsy findings available prior to		
ge 2 sh				completion of causa of daath?		
Page			1 Yes 2□ No	NZÎYes 2□ No		
rector, pag	25. Was cese rafarred to medical 26. Pie	eca of Death (Check				
	examiner?		Rasidence 6 0	Other (Specify)		
funeral din			scribe how injury occ			
tion tion	M 10 Vac 0					
ed in by the funeral Certification:	2 Accidant		ation (Street and Nu	mber or Rural Routa Number,		
in b	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	City	or Town, Stata)			
plately filled in by the funeral edical Certification:	0.0.00					
plately fill edical	29a. Certifier 1☐ Certifying Physician: To the best of my knowledge, deeth occurred at the time, date (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, d	and place, end due deeth occurred at the	to the cause(s) end time, date and plac	menner as stated. e, and due to the cause(s)		
To the Funeral Direct roungletely filled in by Medical Certifi	and manner steted.					
5 1/2	290. Signification and title of certifier 29c. Licanse numbe 0. C.M.E		MARC	med (Month, Day, Year) H 17, 1999		
11	a distriction of the		. 12 31 (C			
M	30. Name and address of person who completed cause of death (Item 23e) (Type, Print)					
- 11	TAKEN LOKE MU 111 Penn Street, Balt	timore, Ma	aryland 21	201		
State	31. Date filed (Month, Day, Yaer)					
Registrar	MAR 1 9 1999 Dans B. Sparks					

